CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

The Mental Retardation (MR) Targeted Case Management and Home and Community-Based Mental Retardation Waiver (MR Waiver) services described in this chapter are covered under the Medicaid Program through a Section 1915(c) Waiver. At the time of the screening for waiver services by the Community Services Board (CSB) or Behavioral Health Authority (BHA), the individual or their legal representative/guardian makes a choice between receiving services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or in the community through the MR Waiver. For the case manager to make a recommendation for MR Waiver services, community based services must be determined to be an appropriate service alternative to delay or avoid placement in an ICF/MR. Providers of such services must meet the qualifications described in Chapter II, "Provider Participation Requirements." Services must be provided in accordance with the service criteria defined in this chapter and in conjunction with the current assessment of the individual's support needs and Consumer Service Plan (CSP) developed for that individual. A provider is reimbursed only for the amount and type of services included in the Individual Service Plan (ISP) authorized by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and documented in the individual's record.

For any MR Waiver service, a qualified case manager employed by or contracted with the CSB/BHA must complete the CSP. The CSP is the combination of a current assessment of the individual's needs in all life areas and the CSP package that describes the services and supports necessary and available under the MR Waiver to address these needs. The ISPs developed by individual service providers (including Case Management) describe the manner in which their services will meet the needs and are incorporated into the CSP. The individual service providers and individual or guardian must participate in the development of the CSP. The providers must submit copies of the ISPs to the case manager for review and retention in the individual's case management file.

TEAM APPROACH FOR COORDINATION OF SERVICES

For individuals receiving MR Waiver services, it is recommended that a team approach be utilized. A team approach helps to ensure the individual's health and safety, and increases the likelihood that the individual's services are coordinated, organized, unduplicated, and provided without breaks in services. Ultimately, a team approach can result in optimal service delivery.

A team approach uses a group of people, (i.e., team members) who work collaboratively with the individual to develop and implement his or her CSP. Teams consist of the individual, the case manager and any individual, provider, or direct service staff. It also may include any family member, legal guardian, authorized representative, or friend whom the individual wishes to involve in the planning process. No team member, with the exception of the individual or legal guardian, possesses any more authority than the other. All team members work on behalf of the individual.

Critical to the team approach is the role the case manager plays in effective team communication, coordination, and monitoring of all of the individual's services. The case manager serves as the team facilitator and is responsible for the development of the CSP. The case manager is responsible for ensuring that all team members have had input into the final CSP. During team meetings, the individual's needs and preferences are identified and discussed. Through team consensus, the individual's goals and objectives are selected. Each provider documents these goals and objectives on their ISP. It is the case manager's responsibility to assure all ISPs are incorporated into the CSP and to monitor implementation of the CSP. Service quality and individual satisfaction is a shared responsibility and is accomplished through effective and consistent communication between the case manager, service providers, and other team members.

The team approach is the basis for decision-making. The individual or case manager, as well as any other team member, may request a team meeting at any time during the plan year. Modifications should not be made to the individual's goals, objectives, activities, or service location without previous communication to the case manager and agreement by the team. This can be done via telephone calls or in a team meeting.

TRANSPORTATION FOR MR WAIVER INDIVIDUALS

The following guidelines should be used when determining whether individuals being served by the MR Waiver will be eligible for transportation services through the transportation broker.

For transportation purposes, community integration trips and field trips are those trips made during the day after the individual has arrived at the clubhouse, center-based provider, or after arrival at the first non-center based activity and before the last non-center based activity. The broker arranges trips from the clubhouse, center-based provider, or the last non-center based activity to the residence of the individual.

MENTAL RETARDATION SERVICES - DAY SUPPORT, PRE-VOCATIONAL, AND SUPPORTED EMPLOYMENT

DMAS will pay for all MR Waiver Services, as long as Medicaid service criteria are met.

<u>Medicaid Payment for Transportation:</u>

1. Payment will be made for transportation from the individual's place of residence or other designated location, such as school, to the enrolled provider and back.

2. Payment will be made for transportation to a respite location of an enrolled provider and back to the residence or other designated location.

3. The time spent transporting the individual to or from the place of residence or other designated location, by the service provider by the staff member providing the service (for example, day support services, congregate residential services, etc.) may be billed if a staff member, in addition to the driver, is required to supervise the individual.

4. The broker will not arrange or pay service providers for transportation for community integration activities.

5. The transportation broker will not request the Individual Service Plan (ISP). The transportation broker may request the Individual Service Authorization Request (ISAR) or a Broker Authorization Form to verify weekly schedules (i.e., which days are authorized for services).

6. The transportation broker will arrange and pay for transportation to and from medical providers for medical appointments.

Center Based Example:

John is picked up at home and taken to the center based day support. The broker arranges for and pays for transportation from John's home to day support. John goes out to lunch during the day with others from the day support program. The broker does not arrange for or pay for transportation to and from lunch. John is picked up from day support and taken home at the end of the day and taken to a Medicaid-funded respite program where he will spend the weekend. The broker arranges for and pays for transportation from day support to the respite program.

Non-Center Based Example:

Sue is picked up from her grandmother's home and taken to her job at McDonald's. Since this is non-center-based supported employment, the broker arranges for and pays for transportation from home to McDonald's. Sue works until noon, at which time she is picked up by the CSB van and goes with other individuals to a movie for the afternoon as part of her treatment goal of socialization. Sue is taken to the CSB after the movie. The broker does not arrange or pay for transportation from McDonald's to the movie and from the movie to the CSB. Sue is picked up from the CSB and taken home. The broker arranges for and pays for transportation from the CSB to Sue's home.

DOCUMENTATION REQUIRED FOR ALL MR WAIVER SERVICES

The provider participation agreement requires that the records fully disclose the extent of services provided to individuals receiving Medicaid services. Records must be made available to authorized state and federal personnel, in the form and manner requested. Records must clearly document the clinical necessity for the service or supports needed, type and schedule of services to be provided, and actual services rendered.

Specific documentation required for each MR Waiver service is described within this chapter. In addition, Medicaid policy regarding the documentation for records of any service provider requires the following:

- The individual must be referenced on each page of the record by full name or Medicaid number;

- Documentation must be legible and clear;
- Signatures are required for all documentation or entries and must include at a minimum, the first initial and last name;
- Errors must be corrected by drawing a line through the incorrect information, adding the correct information, and including the date of the revisions as well as the initials of the person making the revisions. Whiteout or other methods of obliterating the previous documentation may not be used;
- The record must contain the assessment information used to develop the ISP;
- The ISP (and any revisions to it) must be part of the record and reflect the assessment information. All changes in the ISP require supporting documentation;
- All DMHMRSAS and Department of Medical Assistance Services (DMAS) correspondence, including any information relevant to approvals or denials of services, must be in the case management file and available at the applicable provider offices;
- The enrolled provider must develop and maintain written documentation for each service billed. Adequate documentation is essential for audits of billed services. The documentation must include, at a minimum, the type of service rendered, the date and time (when applicable) the service was rendered, the setting in which the service was rendered, the amount of time required to deliver the service, and the signature of the person who rendered the service;
- Progress notes or data collection are also part of the minimum documentation for any agency-directed service billed and are to convey the individual's status and, as appropriate, progress or lack of progress toward goals and objectives in the ISP. If weekly or monthly progress notes are used instead of daily notes, they must clearly reflect the date of entry and the dates of service (e.g., "3/10/00 – For the week of 3/6/00 – 3/10/00: This week in Day Support, Jane . . .);
- Any drugs prescribed as a part of the individual's treatment, including the quantities, dosage, side effects, and reason for use must be entered in the DMAS-enrolled provider's record;
- Written documentation verifying the qualifications of the provider and staff providing the services must be maintained and available for review; and
- Written evidence that information regarding the individual is shared to ensure that services are of high quality, communication flows between private providers and CSB/BHA case managers, and the individual benefits from services provided to him or her.

MENTAL RETARDATION TARGETED CASE MANAGEMENT SERVICES

The Mental Retardation (MR) Targeted Case Management (CM) services covered under the Medicaid Program do not require pre-authorization by DMHMRSAS. However, it is the responsibility of the CSB/BHA to assure that each individual remains eligible and continues to require MR Targeted Case Management services. Although MR Targeted Case Management services do not require pre-authorization, this does not preclude the case management provider from meeting all of the DMAS policies and regulatory guidelines.

Service Definition

MR Targeted Case Management services are activities designed to assist an individual child or adult with mental retardation in accessing needed medical, psychiatric, social, educational, vocational, residential, and other supports essential for living in the community and in developing his or her desired lifestyle.

Activities

The allowable activities include, but are not limited to:

1. Coordinating initial assessment and at least annual reassessment of the individual and planning services and supports, to include the development of a Consumer Services Plan (CSP). This does not include performing medical or psychiatric assessment, but may include referral for such assessment;

2. Coordinating services and treatment planning with other agencies and providers;

3. Linking the individual to services and supports specified in the CSP;

4. Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources, including crisis supports;

5. Enhancing community integration through increasing the individual's community access and involvement;

6. Making collateral contacts to promote implementation of the CSP and community adjustment of the individual;

7. Monitoring implementation of the CSP through regular contacts with service providers, as well as periodic site visits and home visits;

8. Instruction and counseling which guides the individual in problem-solving and decision-making and develops a supportive relationship that promotes implementation of the CSP; and

9. Monitoring the quality of services.

Criteria

Targeted MR Case Management services must be provided by the assigned case manager as frequently and timely as the person needs assistance. There must be at least one documented contact, activity, or communication, as designated above, and relevant to the CSP, during any calendar month for which Targeted MR Case Management services are billed. The activity of writing the case management ISP, quarterly review, or case note is not considered a billable case management activity. Developing the CSP through a team meeting or reviewing other providers' written materials in order to prepare the case management quarterly review are billable activities.

Eligibility

MR Targeted Case Management services may be provided to an individual who is eligible for Medicaid benefits and who is documented to have mental retardation as defined by American Association of Mental Retardation (AAMR) ("being substantially limited in present functioning that is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, manifested before age 18 "). A child under age six years may be considered to have mental retardation as defined by AAMR if there is documented evidence of cognitive and adaptive developmental delay or presence of a syndrome typically associated with mental retardation.

Individuals with MR and children under six years of age who are at developmental risk and who are receiving MR Waiver services are eligible for and must also be receiving Targeted Case Management services during the months that MR Waiver services are received.

To be eligible to receive MR Targeted Case Management services, the individual must need "active case management." An individual is considered to need "active case management" if a minimum of one face-to-face contact is required every 90 days. In addition, a minimum of one scheduled or unscheduled contact or communication by the case manager per month with the individual or with the family, service providers, or other organizations on behalf of the individual must typically be performed.

MR Targeted Case Management services may not duplicate any other Medicaid or MR Waiver service.

Consumer Service Plan

A Consumer Service Plan (CSP) also referred to as a plan of care—must be developed for each individual receiving MR Targeted Case Management services. The CSP organizes and describes the services and supports necessary for meeting an individual's goals and desires for living successfully in the community. An individualized approach should be utilized to assure that functional supports are identified, as well as the individual's desired outcomes; this is coordinated by the case manager, but is a responsibility shared with the individual; legal guardian, if applicable; family members; and service providers. Factors to be considered when

developing this plan may include the individual's age, primary disability, and level of functioning. The CSP includes:

a) The social assessment or individual profile;

b) The primary goals or outcomes of the individual;
c) An Individual Service Plan (ISP) for each MR Community service received by the individual (including MR Targeted Case Management and MR Waiver) which outlines the objectives and activities planned to assist in meeting the individual's goals; and

d) A documentation of agreement (may be a signature page) by those individuals participating in the development and implementation of the CSP.

Social Assessment/Consumer Profile

A comprehensive assessment process must be completed by the case manager to determine the individual's need for services and supports and the outcomes desired from the services. This involves the case manager gathering relevant social, psychological, medical and level of care information and serves as the basis for development of the CSP and component ISPs. The Social Assessment summarizes the assessment information and includes the individual's strengths, personal preferences and desires, and previous services or supports that may or may not have been successful. It summarizes the current status of the individual in the following areas:

a) Physical or Mental Health, Personal Safety, and Behavior Issues;

b) Financial, Insurance, Transportation, and other Resources;

c) Home and Daily Living;

d) Education and Vocation;

e) Leisure and Recreation;

f) Relationships and Social Supports;

g) Legal Issues and Guardianship; and

h) Individual Empowerment, Advocacy, and Volunteerism.

90-Day Case Management

An abbreviated, assessment-oriented ISP may be written and utilized up to a maximum of 90-days for individuals who have not previously received MR Targeted Case Management services from any CSB/BHA and who do not have diagnostic information necessary to determine eligibility for MR Community services. The standard 90-Day Case Management

ISP (see "Exhibits" at the end of this chapter) may be used. The 90-day Case Management documentation should:

a) Include referral information; and

b) Describe the reason for suspecting the presence of mental retardation (or cognitive and adaptive delays in a child less than six years of age) and indicate the probable need for ongoing active case management services.

The 90-day Case Management ISP may begin no earlier than the date of the initial face-to-face contact with the individual and must end when the assessment information is obtained, but no later than 90 days after the start date. However, only three months of billing are permitted. An annual plan must be developed at the point in time during the 90-day assessment period when it is determined that the individual meets eligibility requirements and is in need of active case management. The CSP year begins following the 90-day Case Management, and quarterly reviews would be based upon the start date of the CSP. The 90-Day Case Management does not require a quarterly review; however, a final case note must indicate the results of the 90-day service.

Billing for 90-day Targeted MR Case Management must end when it is determined that the individual is not eligible, regardless of the need for active case management.

Continued Review

The case manager is responsible for continuous monitoring of the appropriateness of the individual's CSP. At a minimum, the case manager must review the CSP every three months to determine whether service goals are being met and whether any modifications to the CSP are necessary.

If there is evidence of serious problems revealed upon MR Targeted Case Management review including 1) the individual, family, or primary caregiver is dissatisfied with services, 2) services are not delivered as described in the CSP, or 3) the individual's health and safety are at risk, the case manager must take necessary actions and document in the individual's appropriate record(s). Actions may include: requesting a written response from the provider; reporting the information to the appropriate licensing, certifying, or approving agency, reporting the information to DMHMRSAS or DMAS; informing the individual of other providers of the service in question; and as a last resort, after all other options have been exhausted, informing the individual that eligibility may be in jeopardy should he or she choose to continue receiving services from a provider who cannot ensure health and safety or other requirements. Any time abuse or neglect is suspected, the case manager is required to inform the Department of Social Services (DSS), DMHMRSAS, and DMAS.

A face-to-face contact with the individual must be made at least once every 90-day period by the case manager. The purpose of the face-to-face contact is for the case manager to observe the individual's status, to verify that services are being provided as described in the ISP(s), to assess the individual's satisfaction with services, and to identify any unmet needs or to

determine changes needed to the CSP. It is recommended that all face-to-face contacts occur in a variety of service settings.

The individual's continued eligibility and need for MR Targeted Case Management services must be reviewed and documented by the case manager at least annually.

Service Units and Service Limitations

A unit of service is equal to a month of service. Billing for the service may begin with the first face-to-face contact and can be submitted only for months in which at least one direct or individual-related contact, activity, or communication occurs and is documented. Reimbursement is provided only for individuals receiving active case management as previously described.

Targeted MR Case Management services may be billed for services provided to Medicaid-eligible institutionalized individuals (including those in acute care hospitals, ICF/MR facilities, and psychiatric hospitals nursing facilities that are not Institutions for Mental Diseases (for individuals ages of 22-64)) during the 30 calendar days preceding discharge. The activities of the case manager may not duplicate the activities of the institutional discharge planner and may be billed no more than twice in a 12-month period.

Provider Documentation Requirements

1. A Consumer Service Plan (CSP)—including the Social Assessment and ISPs—which address the individual's support needs and desires in all life areas must be developed and reviewed and updated at least annually. The CSP and any updates must be retained as part of the case record. The CSP and any updates must document the need for Targeted MR Case Management and be approved, dated, and signed, at a minimum, by the individual (or legal representative) and case manager, with other service providers signing as appropriate.

2. The Targeted MR Case Management ISP (a component of the CSP), which outlines the case management objectives and activities necessary to carry out the CSP. An agency-designed or the standard Case Management ISPs may be used for this purpose. (See "Exhibits" at the end of this chapter).

3. Ongoing documentation, in the form of case notes, must indicate the dates and nature of Case Management services rendered. Documentation of a face-to-face contact every 90 days (with a 10-day grace period permitted) must be in the record. This documentation must clearly state that the case manager was in the presence of the individual, assessed his or her satisfaction with services, determined any unmet needs, evaluated the individual's status, and assisted with adjustments in the services and supports as appropriate. Case notes may take the form of contact-by-contact entries or a monthly summary corresponding with a contact log, which briefly notes the date, type, and nature of each contact. All entries must be signed (first initial and last name minimum) and dated.

4. All relevant communication with the family/caregiver, providers, individual, DMHMRSAS, DMAS, DSS, Department of Rehabilitative Services (DRS), or other related parties must be documented in the record.

5. The CSP must be reviewed every three months (at a minimum) and modified as appropriate to assure that identified needs are addressed and needed services are provided. This must include reviewing the quarterly review of each component ISP. Quarterly review documentation must include any revisions to the CSP, as well as the general status (including health and safety) of the individual, significant events, progress or lack of progress in meeting the CSP, and individual or family satisfaction with services received under the CSP. This quarterly review must include Consumer-Directed services, when applicable.

   The first quarterly review will be due by the last day of the third month from the effective date of the CSP. However, a grace period up to the last day of the fourth month will be given to complete the quarterly review. For example, if the CSP effective start date is 9/15, the first quarter ends on 12/14, making the quarterly report due on 12/31. The report must be completed by 1/31. If the CSP effective date is 7/1, the first quarter ends on 9/30. The report must be completed by 10/31. The day the quarterly is actually completed does not affect the due date for the next review.

6. A new or revised CSP must be developed within 365 days (366 in a leap year) of the effective date of the previous CSP.

7. The case manager must send a letter to the individual notifying him or her of the right to appeal to DMAS if the individual is denied or found ineligible for MR Targeted Case Management, MR Waiver or ICF/MR services or if the individual is placed on the Statewide Waiting List. The case manager must also send a letter if Targeted MR Case Management services are terminated.

Additional Case Management Documentation for Individuals Receiving MR Waiver Services

8. All individuals receiving Mental Retardation Waiver (MR Waiver) services must receive MR Targeted Case Management services. An individual must be formally enrolled into waiver services by DMHMRSAS. Once the case manager has determined an individual meets the functional criteria for MR Waiver services, the individual has chosen Waiver services and an available slot has been verified by DMHMRSAS, the team will meet within 30 calendar days to discuss the individual's needs, existing supports, agency-directed and consumer-directed service options and to develop a Consumer Service Plan. Additional Case Management documentation requirements for individuals receiving MR Waiver services include the following:

   a. The case manager is responsible for the coordination and maintenance of the individual's required medical, psychological, functional, and social assessments, as well as the ICF/MR Level of Functioning Survey (LOF) (see "Exhibits" at the end of this chapter). Medical examinations and social assessments shall be current and

completed prior to the entry to the MR Waiver, no earlier than one year prior to beginning MR Waiver services. Psychological evaluations or standardized developmental evaluations for children under six must reflect the current psychological status (diagnosis), current cognitive abilities, and current adaptive level of functioning. A DMHMRSAS approved functional assessment tool, must also be used in the assessment process and maintained in the individual's record. Annual reassessments must be obtained for the functional assessment and LOF, and summarized in the Social Assessment. A new psychological assessment must be obtained at such time as the existing assessment fails to reflect the individual's current psychological status, cognitive abilities and adaptive functioning. Medical reassessment must be completed as needed for adults and in accordance with Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) schedule requirements for children (see the "Exhibits" section at the end of this chapter);

b. The Consent to Exchange Information form (DMAS-20 or another form developed by the provider that services the same purpose) must be completed to initiate Waiver services. (See "Exhibits" at the end of this chapter.);

c. The Documentation of Recipient Choice Between Institutional Care or Home and Community-Based Services (recipient choice form), indicating the individual's desire for MR Waiver services over institutional placement, is required at the initiation of services and should be maintained in the individual's case management record (see the "Exhibits" section at the end of this chapter);

d. There must be documentation that the choice of provider(s) has been offered when MR Waiver services are initiated, when there is a request for a change in provider(s), when additional services are initiated, or when the individual is dissatisfied with the current provider. Choice must be documented in writing by having the individual (or parent or guardian when appropriate) sign a list of available providers and designate the selected provider(s). It is recommended that this documentation be completed on a separate CSB/BHA form, readily available for review, which lists the available providers and indicates the choice made by the individual;

e. Documentation must be in the case management record that the individual has been presented with all feasible alternatives of available agency and consumer-directed services for which he or she is eligible under the MR Waiver (this can be done on the recipient choice form);

f. All providers' ISPs are components of the CSP and must be reviewed and maintained by the case manager for a period not less than five years from the start of MR Waiver services;

g. The Plan of Care Summary completed by the care manager states the primary goals for the individual, presents assessment results, includes the full range of services

and supports the individual receives, and other information needed for DMHMRSAS to pre-authorize services. (See "Exhibits" at the end of this chapter).

h. For each individual receiving MR Waiver services, there must be a copy of the DMH 855E 1164 (MR Waiver Level of Care Eligibility Form) and the initial DMAS-122 (Patient Information) form (see the "Exhibits" section at the end of this chapter) and updates of the DMAS-122 as required. (See the "DMAS-122 Requirement" section later in this chapter for specific reasons a case manager must submit a DMAS-122 to DSS and DMHMRSAS). DMAS-122 forms are updated annually by the eligibility worker at the local department of Social Services. DMAS-122 forms may be updated more frequently if a change occurs in the individual's eligibility for Medicaid. Copies of updated DMAS-122 forms must be forwarded to all service providers by the case managers. Each annual (or other) update must be in the individual's file maintained by the case manager and in a file maintained by each provider. In the event that the DMAS-122 is not generated by the local DSS in a timely fashion, the case manager should document all attempts to obtain it, including the names and phone numbers of local DSS staff contacted. The case manager should notify DMHMRSAS of all situations in which receipt of the DMAS-122 is inordinately delayed and inform involved providers of the circumstances as well.

i. The case manager is required to make monthly onsite visits to individuals receiving any MR Waiver services who reside in Assisted Living Facilities licensed by DSS. The visits are to occur when the individual is present. For each individual, the following must be documented in the case notes:

- Any issues related to the individual's health and safety;
- Individual satisfaction with ALF service delivery and place of residence; and
- Staff interactions and types of services the individual is receiving while the case manager is present.

The case manager is responsible for responding to any health and safety concerns and reporting unresolved health and safety concerns to DMHMRSAS. Licensing and abuse problems must also be reported to the Department of Social Services' (DSS) local Adult Protective Services or Child Protective Services.

This information must be summarized in the quarterly review.

MENTAL RETARDATION WAIVER SERVICES

DMAS will reimburse for a range of home and community-based services for persons with mental retardation under the authority of Section 1915(c) Waivers. The services, eligibility determination, authorization process, and provider requirements set forth in this manual apply to Mental Retardation (MR) Waiver programs.

The MR Waiver program is targeted to provide home and community-based services to individuals with mental retardation and children under the age of six years at developmental risk (defined as the presence before, during or after an individual's birth, of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through diagnostic and evaluative criteria) who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for Waiver services. At the age of six years, children at developmental risk must be diagnosed with mental retardation (as defined by AAMR) in order to continue to receive MR Waiver services.

MR Waiver services may include elements of training, assistance, or specialized supervision that allow an individual to achieve or maintain optimum functioning. They may also include those supports that allow an individual to continue living with family or in another community residence. The Consumer Service Plan (CSP) must clearly document the areas in which training, assistance, specialized supervision, and other supports are needed. Individual Service Plans (ISP) must identify the specific types of training, assistance, specialized supervision, and other supports to be provided within the specific MR Waiver services. An individual may receive a minimum of one MR Waiver service, with the exceptions of Environmental Modifications, Assistive Technology, and Therapeutic Consultation services (other than Behavior Consultation), which may only be provided to individuals who are receiving at least one other MR Waiver service. Behavior Consultation may be offered in the absence of any other MR Waiver service when the consultation is determined necessary to prevent institutionalization.

The case manager must present the individual with a choice of consumer-directed services or agency–directed services (or a combination of the two service delivery models). When the individual chooses consumer-directed services, the case manager offers the individual a choice of CD Services Facilitators. The CD Services Facilitator assists the individual with employing, managing, and maintaining consumer-directed companions or assistants.

All individuals receiving MR Waiver services must receive MR Targeted Case Management services. Service and documentation requirements for MR Targeted Case Management are described in the Case Management section of this chapter.

The MR Waiver services are included in the CSP by the case manager and require pre-authorization by DMHMRSAS. The services, allowable activities, criteria, units, limitations, documentation and pre-authorization requirements are described below.

Individuals residing in Medicaid-covered Therapeutic Foster Care placements are not eligible to receive any MR Waiver services.

RESIDENTIAL SUPPORT SERVICES

Service Definition

Residential Support services consist of training and assistance or specialized supervision, provided primarily in an individual's home or in a licensed or approved residence considered to be his or her home, to enable the individual to acquire, improve, or maintain his or her health status, to develop skills in activities of daily living and safety in the use of community resources and adapting his or her behavior to community and home environments. Emphasis should be on a person-centered approach that empowers and supports each individual in developing his or her own lifestyle. Residential Support may not include room and board or general supervision. MR Waiver services will not be routinely provided for a continuous 24-hour period.

Residential Support services may be provided as Supported Living/In-Home Supports or as Congregate Residential Support. The distinction is based on the service setting that provides the services, the ratio of staff to individual(s) and whether services are routinely provided by paid staff across a continuous 24-hour period.

Supported Living/In-Home Supports are supplemental to the primary care (i.e., room and board or general supervision) provided by a parent or similar caregiver. This service may also support an individual whose level of independence does not require a primary care provider. The usual setting is a private residence (such as a home or apartment). A Residential Support staff person comes to the residence to provide services. Supported Living/In-Home Supports are delivered on an individualized basis according to the ISP and are delivered primarily with a 1:1 staff-to-individual–ratio except when training protocols require parallel or interactive intervention. Both primary care and Residential Support services are not routinely provided by paid staff of the Supported Living/In-Home Supports provider across a continuous 24-hour period.

Congregate Residential Support is training, assistance and specialized supervision provided to an individual living 1) in a group home, 2) in the home of the care provider who also provides the MR Waiver services (such as Adult Foster Care or Sponsored Placement) or 3) in an apartment or other home setting, with one or more individuals also receiving MR Waiver Residential Support services from the same staff at the same time, and delivered according to the ISP, including individual or group situations.

For individuals who live in a DSS-licensed Assisted Living Facility (ALF) or with a DSS-approved Adult Foster Care or Family Care provider (AFC), MR Waiver Residential Support services may be either Supported Living/In-Home or Congregate Residential Support. If an external Residential Support provider sends a staff person into the ALF or AFC residence to provide services, it is Supported Living/In-Home Residential Support. If the AFC provider is the Residential Support provider, it is Congregate Residential Support. If the ALF provider provides MR Waiver Residential Support and the provider has applied to DMHMRSAS for a Residential Services license by September 12, 2001, the provider may continue to bill for Congregate

Residential Support services under their DSS license until September 15, 2002. However, a provider must be licensed by DMHMRSAS by September 15, 2002 to continue billing Congregate Residential Support services beyond September 15, 2002.

Activities

The allowable activities include, but are not limited to:

1. Training in functional skills related to personal care activities (toileting, bathing, and grooming; dressing; eating; mobility; communication; household chores; food preparation; money management; shopping, etc.);

2. Training in functional skills related to the use of community resources (transportation, shopping, restaurants, social and recreational activities, etc.);

3. Training in adapting behavior for community and home and community environments, for example (not all inclusive):

   - Developing a circle of friends;
   - Handling social encounters with others; or
   - Redirecting anger toward others.

4. Monitoring health and physical condition and assistance with medication or other medical needs;

5. Assisting with personal care, activities of daily living, and use of community resources, for example (not all inclusive):

   - Completing personal care tasks when physically unable to learn to do so;
   - Ensuring hygiene and eating needs are met, such as hand-over-hand shaving or tooth brushing; or
   - Completing daily tasks, such as laundry, meal preparation, using the bank, or other tasks essential to the individual's health and welfare.

6. Assisting with transportation to and from training sites and community resources; and

7. Providing specialized supervision to ensure the individual's health and safety.

Criteria

60-Day Assessment

A functional assessment should be conducted to evaluate each individual in his or her home environment and community settings. A provider may use a 60-Day Assessment period while evaluating the individual's need for specific training, assistance, specialized supervision, and supports. If a provider utilizes an assessment period prior to developing an annual ISP, a preliminary ISP must be submitted to the case manager, and include the areas to be evaluated and a schedule of services to be provided. The standard 60-Day Assessment ISP may be used for this purpose (see ISPs in "Exhibits" at the end of this chapter). Prior to the last day of the assessment period, if the individual wishes the services to continue, the provider, with the involvement of the individual, must develop an annual ISP and forward it to the case manager for review. The start date of the annual ISP must be no later than day 61 and ends when the annual CSP ends.

General Supervision

State regulations prohibit costs for room, board, and general supervision from being billed to Medicaid under the MR Waiver program.

Supported Living/In-Home Supports may not supplant primary care (i.e., room, board, and general supervision) available to the individual through non-medical sources (e.g., family, foster care provider, etc.). It may provide only the supplemental assistance and training required to maintain the capacity of the primary care provider to offer care.

Congregate Residential Support services cannot be authorized unless the individual requires training and support services, which exceed the room, board, and general supervision included in the individual's residential arrangement. Those services authorized for reimbursement under the MR Waiver may not duplicate those that the provider is required to offer in the residential arrangement.

General supervision consists of the need for staff presence without evidence of the individual's need for staff intervention. General supervision may help assure that appropriate action is taken in an emergency or if an unanticipated incident occurs. However, routine staff activities, such as the examples described below, are not evidence of an individual's need for staff intervention and are therefore considered to be general supervision. Examples (not all-inclusive) of general supervision that may not be billed to Medicaid are:

- Awake staff coverage during nighttime hours if an individual generally sleeps through the night and has no documented medical or behavioral problems that indicate a need for staff intervention to ensure health and safety;
- Routine bed checks;
- Oversight of leisure activities;

- Asleep staff at night on the premises for security or safety reasons, or both; or
- Staff "on call" during the day while individuals are at a day program or supported employment placement.

Specialized Supervision

Specialized supervision provides staff presence for ongoing or intermittent intervention to ensure an individual's health and safety. For Medicaid to reimburse for specialized supervision, the ISP must clearly document the individual's need for specialized supervision. The ISP must indicate what specialized supervision activities the staff will perform and when. Documentation should reflect specialized activities that relate to the individual's health and safety needs and indicate occurrences of those needed supports. The intervention provided may be ongoing or intermittent, and the amount of time included in the ISP must be based on the individual's assessed needs.

In the case of awake overnight staff coverage in a residential support plan, specialized supervision *may* include hours throughout the entire night, *but only* if assessment information documents ongoing night needs. In some cases, an individual may need staff intervention on a regular but *unpredictable* basis. For example, an individual who has a documented history of uncontrolled seizure disorder, may need overnight specialized supervision in the form of staff assistance due to the unpredictable nature of the disorder, as well as active intervention when seizures occur. In such a case, specialized supervision may be included throughout the night.

In other cases, an individual may require predictable specialized supervision, such as assistance with toileting at some point each night. Only the amount of time typically involved in providing assistance may be included in the residential support plan as specialized supervision.

For reauthorization of specialized supervision, there must be clear documentation in the individual's record of the ongoing need for the service and the staff intervention provided.

Restrictions with Other Services

Residential Support services may not be provided to any individual who receives Personal Assistance services under the MR Waiver.

A case manager may not be the direct service staff or the immediate supervisor of a direct service care staff to an individual for whom he or she is providing Case Management services.

Residential Support under the MR Waiver is not allowable in another residential program that provides a comparable level of service, as in Assisted Living services in an ALF. Individuals who receive Assisted Living services may still be enrolled in the MR Waiver and receive certain *other* MR Waiver services (such as Day Support), but the ALF may not receive payment for Assisted Living services and at the same time bill for MR Waiver Residential Support services.

When an individual receives MR Waiver Residential Support services from an ALF, only those services that are beyond the requirements of the duties specified by DSS will be covered (until September 15, 2002, at which time Residential Support services delivered by the ALF must cease). Approval of Residential Support allowable activities in a MR Waiver ISP for an individual living in an ALF will be guided by the following criteria:

1. Services required to be provided by ALFs, and therefore, not allowed under the MR Waiver, are:

    - General supervision;
    - Assistance in medication administration;
    - Room and board;
    - Help with bathing, dressing, eating, oral hygiene, hair grooming and shampooing, shaving, nail care, menstrual care, caring for needs associated with occasional bladder or bowel incontinence;
    - Help with caring for personal possessions, use of the telephone, arranging transportation, obtaining necessary personal items and clothing, correspondence;
    - Help with securing health care and transportation for needed medical treatment;
    - Recreational opportunities scheduled for at least 11 hours per week;*
    - Physical help required to attend recreation or meals; and
    - Development of a written ISP on each resident.

    *If required, social and recreational activities are scheduled and held during a time when the individual receiving MR Waiver services is not present (e.g., he or she is at Day Support); in such cases, the ALF operator is not obligated to arrange an equivalent number of hours of social and recreational activities at another time for that individual, and the MR Waiver may be used to pay for other social or recreation activities, or both, if the individual's ISP lists that as a need.

2. The ALF must submit a copy of its ALF ISP, along with the MR Waiver Residential Support ISP to the CSB/BHA case manager. The case manager must review both ISPs to assure that the MR Waiver ISP only includes those allowed activities and specialized supervision that are not the responsibility of the ALF. Duplicative hours and services cannot be included. The CSB/BHA case manager must indicate on the Plan of Care Summary (or on the Individual Service Authorization Request (ISAR) if this is a service or provider modification) that the MR Waiver services will be provided in an ALF.

Other Criteria

The amount and type of Residential Support services that can be authorized are determined by the individual's assessed training and support needs reflected in the CSP and Residential Support ISP. Residential Support services should be provided at a frequency that allows for systematic training and maintenance of functional supports.

The Residential Support ISP must indicate the necessary amount and type of activities required by the individual, the schedule of residential support services, the total number of hours per day, and the total number of hours per week of residential support.

Residential Support services may be offered on a periodic basis, as long as the Residential Support ISP documents the individual's needs and reflects appropriate and allowable activities to be provided on a periodic basis. Periodic residential support services are not covered when the activities to be performed are not allowable activities as described for Residential Support services (i.e., services, such as respite services where the care provider "sits" with the individual or provides general supervision).

The case manager may request a change in the amount of authorized hours for Residential Support services on the Residential Support ISP at any time this is justified by individual need. (See "Authorization of Mental Retardation Waiver Services" in this chapter for details.)

Medicaid reimbursement is available only for Residential Support services provided when the individual is present and when a qualified provider is providing the services.

Service Units and Service Limitations

Congregate Residential Support may be reimbursed on an average daily amount of hours established per individual. The average daily amount is determined by multiplying the total hours scheduled per week by 4.3 and dividing the results by 30. The average daily amount is used for billing purposes only. Whenever *any portion* of the training, assistance, or specialized supervision authorized in the Residential Support ISP is provided during a day, the entire average daily amount of hours may be billed. Documentation of activities must be maintained by the provider in a daily format and should demonstrate that the individual is regularly receiving services as scheduled. If the hours actually provided are consistently less, over a 60-day period, than the schedule upon which the average daily amount is determined, the provider should revise the Residential Support ISP, the weekly schedule and the average daily amount to reflect this reduction. This revision is reviewed by the case manager and authorized by DMHMRSAS, as appropriate. No more than 30 days per month (28/29 days in February) may be billed when billing is based on the average daily amount.

Supported Living/In-Home Supports are reimbursed on an hourly basis for the time the Residential Support staff is working directly with the individual. Total billing cannot exceed the total hours authorized by the ISAR. When unavoidable circumstances occur so that a provider is at the individual's home at the designated time but cannot deliver part of the

services due to individual or family related situations (such as unanticipated lateness or illness of the individual or family emergency), billing will be allowed for the *entire* number of hours scheduled for that day, as long as *some portion* of the ISP is provided. The provider must maintain documentation of the date, times, services that were provided and specific circumstances, which prevented provision of all of the scheduled services. If fewer hours than scheduled in the ISP are delivered on a regular basis over a 60-day period, the case manager should determine the reasons, and determine whether a new ISP, with fewer hours or a change in schedule, may need to be developed.

Periodic Support hours may be included in the ISP, when it is anticipated that additional hours of Residential Support over and above those regularly scheduled will be needed due to semi-predictable events, such as illness of the individual, inclement weather, closing of a day program. The regular ISP activities may be provided during these additional hours; however, the ISP should confirm this or add a specific objective that would apply to those times when Periodic Support hours would be used.

The number of additional Periodic Support hours per month to be authorized by DMHMRSAS is determined by estimating the maximum possible number of hours in any month an individual may need additional residential support.

Periodic Support hours must be individually determined and documented for each individual. The recommended form for documenting Periodic Support hours is "Determining Periodic Support Hours," which is located in the "Exhibits" at the end of this chapter along with instructions for its use.

Providers of Congregate Residential Support that bill DMAS using the average daily amount of hours are reminded that the average daily amount is *not changed* when Periodic Support hours are also used. Any Periodic Support hours provided in the month are included in the total number of average daily amount hours for billing purposes. (See Chapter V for additional billing instructions.)

Provider Documentation Requirements

The requirements are:

1. For DMHMRSAS licensed programs, an ISP must be consistent with licensing regulations;

2. If not a DMHMRSAS licensed program, there must be an ISP, which contains, at a minimum, the following elements:

    a. The individual's strengths, desired outcomes; required or desired supports, or both; and training needs;

    b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

c. The services to be rendered and the schedule of services to accomplish the above goals and objectives;

d. The person(s) or organization(s) that will provide the services specified in the statement of services;

e. A timetable for the accomplishment of the individual's goals and objectives;

f. The estimated duration of the individual's needs for services; and

g. The person(s) responsible for the overall coordination and integration of the services specified in the plan.

2. The appropriate Individual Service Authorization Request Form (ISAR) must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see "Exhibits" for sample forms). If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS provider participation agreement.

3. There must be a copy of the current DMAS-122 (Patient Information) form (see "Exhibits" at the end of this chapter) in the record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

4. During the period when a 60-Day Assessment is used, documentation must confirm the individual's attendance and amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Assessment section of the ISP objectives. The data or assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the 60-Day Assessment ISP. For example, the ISP may prescribe that staff take data on activities of living on a daily basis using a task analysis, scatter plot, or checklist format. Another individual's ISP might suggest a more informal approach to get to know the person in a variety of settings and activities, with this data/information collected in a more subjective, anecdotal fashion. Assessment results should be available in at least a daily note or a weekly summary. Data should be collected as described in the ISP, analyzed, summarized, and then, clearly addressed in the regular ISP;

5. Documentation must indicate the dates and times of Residential Support services and the amount and type of activities provided. The format for documentation of Residential Support services should be reviewed by DMHMRSAS staff prior to use;

6. When Periodic Support hours are used, the provider of Residential Support services must document delivery of those hours. Documentation must include a) the date Periodic Support hours were used; b) the reason the individual did not

participate in normally scheduled day activities or needed additional residential support; c) the training, assistance, or specialized supervision provided to the individual; and d) the number of Periodic Support hours provided. Documentation of these additional activities could be made on progress/case notes, or data sheets or logs, etc. The approved ISP activities for Residential Support services can be completed during these additional hours; however, the ISP should confirm this or add a specific objective that would apply when Periodic Support hours are used.

7. The ISP must be reviewed by the provider and this review submitted to the case manager, at least quarterly, with goals, objectives, and activities modified as appropriate. Quarterly review documentation must include any revisions to the ISP and also address the general status of the individual, significant events, and individual or family, or both, satisfaction with services. The due date for the quarterly review is determined by the effective start date of the CSP and communicated to the provider by the case manager. A ten-day grace period is permitted.

PERSONAL ASSISTANCE SERVICES (AGENCY-DIRECTED)

Service Definition

Personal Assistance services mean direct support with personal assistance, activities of daily living, community access, medication and other medical needs, and monitoring health status and physical condition. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

Activities

The allowable activities include, but are not limited to:

1. Assistance with activities of daily living (ADLs), such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.;

2. Assistance with monitoring health status and physical condition;

3. Assistance with medication and other medical needs;

4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);

5. Assistance with housekeeping activities, such as bed making, dusting, and vacuuming, laundry, grocery shopping, etc., when specified in the individual's ISP and essential to the individual's health or welfare, or both;

6. General support to assure the safety of the individual;

7. Assistance and support needed by the individual to participate in social, recreational and community activities; and

8. Accompanying the individual to appointments or meetings.

Attending to Personal Care Needs of Individuals Who Work or Attend School, or Both

Individuals who wish to enter the MR Waiver may continue to work or attend school, or both, while they receive services under this waiver. The personal care attendant who assists the individual may accompany that person to work/school and may assist the person with personal care needs while the individual is at work/school. DMAS will pay for any personal care related services that are given by the aide to the enrolled individual while the individual is at work/school. DMAS will also pay for any personal care services that the aide gives to the enrolled individual to assist him or her in getting ready for work/school or when he or she returns home.

DMAS will not pay for the aide to assist the enrolled individual with any functions related to the individual completing his or her job/school functions or for supervision time during work or school.

DMAS will review the individual's needs and the complexity of the disability when determining the services that will be provided to the individual in the workplace/school.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973. For example, if the individual's only need is for assistance during lunch, DMAS would not pay for the aide for any time extending beyond lunch. For an individual whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make himself understood even with a communication device, the aide's services may be necessary all day. DMAS will reimburse for the aide's services unless the aide is required to assist the individual all day as a part of the ADA or the Rehabilitation Act of 1973.

The provider or support coordinator must develop an individualized plan of care that addresses the individual's needs at home, work, and/or in the community.

Example: Mr. Jones is enrolled in the MR Waiver. He works outside the home for five (5) hours each day. His attendant assists him with getting ready for work in the morning and accompanies Mr. Jones to work. The attendant may assist Mr. Jones with any personal care needs such as bathroom needs during the time that Mr. Jones is at work. Mr. Jones actually requires his attendant's assistance for a combined total of one (1) hour per day during the five-hour period that he is working, but the aide is providing supervision for the total five-hour period. The individual's POC must include the full five hours for the provider to be reimbursed by DMAS.

Criteria

The individual must require some assistance with activities of daily living (ADLs) in order for Personal Assistance services to be authorized.

Training is not expected under Personal Assistance services.

60-Day Assessment

A functional assessment should be conducted to evaluate each individual in his or her home environment and community settings. A provider may elect to use a 60-Day Assessment while evaluating the individual's need for specific assistance, supervision, and supports. If a provider utilizes an assessment period prior to developing an annual ISP, a preliminary ISP must be submitted to the case manager, and include areas to be evaluated and a schedule of services to be provided. The standard 60-Day Assessment ISP (see ISPs in "Exhibits" at the end of this chapter) may be used for this purpose. Prior to the last day of the assessment period, if the individual wishes the services to continue, the provider, with the involvement of the individual, must develop an annual ISP and forward it to the case manager for approval. The start date of the annual ISP would be no later than day 61 and would end when the annual CSP ends.

Restrictions with Other Services

Personal Assistance services may not be authorized for an individual who receives MR Waiver Residential Support or who is living in a licensed Assisted Living Facility. These services are available for individuals for whom training and skills development are not primary objectives or are received in another service or program. This service may not supplant an appropriate training program when an individual has the capacity to gain increased independence. For Personal Assistance services to be approved, the case manager, along with the individual, must determine that training is not appropriate or is offered through another service.

Personal Assistance services may not be provided during the same billable hours as MR Waiver Supported Employment or Day Support. Limited exceptions may be requested of DMHMRSAS if Personal Assistance services are required during the same billable hours as Supported Employment for individuals who have severe physical disabilities.

Other Criteria

The individual must have a back-up plan (e.g. a family member, neighbor or friend willing and available to assist the individual) in case the personal assistant does not show up for work as expected. The provider is not responsible for providing backup assistance. This is the responsibility of the individual and family and must be identified in the ISP. Individuals who do not have a back-up plan are not eligible for these services until they have developed one.

The case manager may request a change in the amount of authorized hours for Personal Assistance services on the ISP at any time this is justified by individual need. (See "Authorization of Mental Retardation Waiver Services" in this chapter for details.)

Medicaid reimbursement is available only for Personal Assistance services provided when the individual is present and when a qualified provider is providing the services to the individual.

The RN supervisor (for DMAS enrolled Personal Care/Respite providers) or residential services supervisor (for DMHMRSAS licensed agencies) must make an initial assessment home visit prior to the start of services for all new individuals admitted to personal assistance. The designated RN supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

The RN or LPN (for DMAS enrolled Personal Care/Respite providers) or residential services supervisor (for DMHMRSAS licensed agencies) must make supervisory visits as often as needed to ensure both quality and appropriateness of services. The minimum frequency of these visits is every 30 - 90 days depending on individual's needs.

Inability of an agency to provide services and substitution of assistants

When a personal assistant is absent and the provider has no other personal assistant available to provide services, the provider is responsible for ensuring that services continue to be provided to the individual within a reasonable amount of time.

1. If a provider cannot supply a personal assistant to render authorized services, the provider may either obtain a substitute assistant from another provider, if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the individual's services to another provider. The personal assistance provider that has the authorization to provide services to the individual must contact the case manager to determine if additional preauthorization is necessary.

2. If no other provider can supply a personal assistant, the provider shall notify the individual or family and case manager so that they may find another available provider of the individual's choice. Pre-authorization by DMHMRSAS is required in those cases in which the services are transferred to another provider.

3. During temporary, short-term lapses in coverage, not to exceed two weeks in duration, a substitute personal assistant may be secured from another personal assistance provider or other home health care provider. Under these circumstances, the following requirements apply:

    a. The preauthorized provider is responsible for providing the supervision for the substitute assistant.

    b. The preauthorized personal assistance provider must obtain a copy of the assistant's daily records signed by the individual and the substitute assistant from the personal assistance provider providing the substitute assistant. All documentation of services rendered by the substitute assistant must be in the individual's record. The documentation of the substitute assistant's qualifications must also be obtained and recorded in the personnel files of the

preauthorized provider. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant.

c. Only the preauthorized provider may bill DMAS for services rendered by the substitute assistant.

4. If a provider secures a substitute assistant, the provider is responsible for ensuring that all DMAS requirements continue to be met including documentation of services rendered by the substitute assistant and documentation that the substitute assistant's qualifications meet DMAS' requirements.

Service Units and Service Limitations

The unit of service for Personal Assistance services is one hour.

The amount of Personal Assistance services that can be authorized is determined by the individual's assessed needs and required supports. When two individuals who live in the same home request Personal Assistance services, the provider will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. The amount of time for tasks which could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and the hours split between the individuals. (For example, individual "A" might have 3 hours for bathing, dressing and toileting, while individual "B" might have 2 hours for bathing and dressing. They would share the assistant's time that totals 4 hours for housekeeping, laundry and meal preparation. Therefore, individual "A's" weekly hours would total 5, while individual "B's" weekly hours would total 4.) The number of hours that may be billed is limited to the total number of hours worked by the personal assistant. (In this example, the total hours billed would be 9.)

Periodic Support hours may be included in the ISP, when it is anticipated that additional hours of Personal Assistance over and above those regularly scheduled will be needed due to semi-predictable events, such as illness of the individual, inclement weather, closing of a day program. The regular ISP activities may be provided during these additional hours; however, the ISP should confirm this or add a specific objective that would apply to those times when Periodic Support hours would be used.

The number of additional Periodic Support hours per month to be authorized by DMHMRSAS is determined by estimating the maximum possible number of whole or part days in any month an individual may need additional personal assistance.
Periodic Support hours must be individually determined and documented for each individual. The recommended form for documenting Periodic Support hours is "Determining Periodic Support Hours," which is located in "Exhibits" at the end of this chapter, along with instructions for its use.

Provider Documentation Requirements

1. An initial assessment, completed by the designated supervisor prior to or on the date services are initiated, (and subsequent reassessments, as needed) must be in the individual's record.

2. Personal Assistance services must have an individual-focused ISP, which includes the specific assistance which will be provided and the approximate time which will be allowed for each activity. A provider-designed ISP, the Provider Agency Plan of Care form (DMAS-97A in "Exhibits" at the end of this chapter), or the standard Personal Assistance ISP (see ISPs in "Exhibits" at the end of this chapter) may be used for this purpose.

3. Documentation indicating the dates and times (arrival and departure) of Personal Assistance services and amount and type of service provided must be in the individual's record. The Aide Record form (DMAS-90) may be used for this purpose. (See "Exhibits" at the end of this chapter). Any other format for documentation of hours of Personal Assistance services should be reviewed by DMHMRSAS staff prior to use.

4. The appropriate Individual Service Authorization Request (ISAR) form must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see "Exhibits" for sample forms). At annual review points for which a new ISAR is not required (i.e., no change in level of service), the provider must still ensure the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS provider agreement.

5. There must be a copy of the current DMAS-122 (Patient Information) form (see "Exhibits" at the end of this chapter) in the patient's record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

6. During a period when a 60-Day Assessment is used, documentation must confirm attendance or amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Assessment ISP objectives. The data/assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the 60-Day Assessment ISP. For example, the ISP may prescribe that staff take traditional baseline data on a daily basis using a task analysis, scatter plot, or checklist format. Another individual's ISP might suggest a more informal approach to get to know the person in a variety of settings and activities, with this data/information collected in a more subjective, anecdotal fashion. Assessment results should be available in at least a daily note or weekly summary. Data should be collected as described in the ISP, analyzed, summarized, and then, clearly addressed in the annual ISP.

7. When Periodic Support hours are used, the provider of Personal Assistance services must document delivery of those hours. Documentation must include a) the date, b) the reason the individual did not participate in normally scheduled day activities, c) the assistance or general supervision provided to the individual, and d) the number of Periodic Support hours provided. Documentation of these additional activities could be made on progress or case notes, or both; data sheets or logs; etc. The approved ISP activities for Personal Assistance services can be completed during these additional hours; however, the ISP should confirm this or add a specific objective that would apply when Periodic Support hours are used.

8. The designated supervisor's (RN or LPN for Personal Care/Respite providers or residential services supervisor for DMHMRSAS-licensed agencies) written summaries of supervision visits must note:

    a. Whether personal assistance services continue to be appropriate;

    b. Whether the plan is adequate to meet the need or changes are indicated in the plan;

    c. Any special tasks performed by the personal assistant (e.g., assistance with bowel/bladder programs, range of motion exercises, etc. See "Exhibits" for more details.) and the personal assistant's qualifications to perform these tasks;

    d. The individual's satisfaction with the service;

    e. A hospitalization or change in medical condition or functioning status;

    f. Other services received and their amount; and

    g. The presence or absence of the assistant in the home during the supervisor's visit.

9. The personal assistant provider's record must contain:

    a. The specific services delivered to the individual by the personal assistant and the individual's response;

    b. The arrival and departure time of the assistant for personal assistance services;

    c. Comments or observations recorded weekly about the individual. Assistant comments must include, at a minimum, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered;

d. The signature of the personal assistant and the individual or caregiver once each week to verify that personal assistance services have been rendered; and

e. Signature, time and dates shall not be placed in the record prior to the date that the services are delivered.

10. The ISP must be reviewed by the provider and this review submitted to the case manager, at least quarterly with modifications made as appropriate. Quarterly review documentation must include any revisions to the ISP and also address the general status of the individual, significant events, and the individual's or family's, or both, satisfaction with services. The due date for the quarterly review is determined by the effective start date of the CSP and communicated to the provider by the case manager. A ten-day grace period is permitted.

PERSONAL EMERGENCY RESPONSE SYSTEM

Service Definition

Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. PERS electronically monitors individual safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication monitoring devices.

DMAS will only reimburse services as defined in the service description, documented in the individual's approved CSP, and that are within the scope of practice of the providers performing the service.

Criteria

PERS services are limited to those individuals who live alone or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. Medication monitoring units must be physician ordered and are not considered a stand-alone service. Individuals must be receiving PERS services and medication monitoring services simultaneously.

PERS can only be authorized when no one else is in the home who is competent or continuously available to call for help in an emergency.

Service Units and Service Limitations

A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month

rental price set by DMAS. The one time installation of the unit(s) shall include installation, account activation, individual and caregiver instruction, and removal of equipment.

PERS services shall be capable of being activated by a remote wireless device and be connected to the individual's telephone line. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The activating device shall be waterproof, shall automatically transmit, to the response center, an activator low battery alert signal prior to the battery losing power, and be able to be worn by the individual.

In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a Registered Nurse or a Licensed Practical Nurse. The units can be refilled every 14 days.

The PERS provider is prohibited from performing all types of direct marketing activities to Medicaid recipients. Direct marketing means (1) conducting directly or indirectly door-to-door, telephonic, or other "cold call" marketing of services at residences and provider sites; (2) mailing directly; (3) paying "finders fees;" (4) offering financial incentives, rewards, gifts or special opportunities to eligible individuals as inducements to use their services; (5) continuous, periodic marketing activities to the same prospective individual, e.g., monthly, quarterly, or annual give-aways, as inducements to use their services; OR (6) engaging in marketing activities that offer potential customers rebates or discounts in conjunction with the use of their services or other benefits as a means of influencing individuals' use provider's services.

Additional PERS Requirements

The PERS provider must properly install all PERS equipment into the individual's functioning telephone line and must furnish all supplies necessary to ensure that the system is installed and working properly.

The PERS installation shall include local seize line circuitry, which guarantees the unit to have riority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

A PERS provider must maintain all installed PERS equipment in proper working order.

The PERS provider must have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Standards for PERS Equipment

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard Number 1635 for Digital Alarm Communicator System Units and Number 1637, which is the UL safety standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard. The PERS device must be

automatically reset by the response center after each activation, ensuring that subsequent signals can be transmitted without requiring manual reset by the individual.

A PERS provider shall furnish education, data, and ongoing assistance to DMAS and/or DMHMRSAS to familiarize staff with the service, allow for ongoing evaluation and refinement of the program and shall instruct the individual, caregiver, and responders in the use of the PERS service.

The emergency response activator must be activated either by breath, by touch, or by some other means, and must be usable by persons who are visually or hearing impaired or physically disabled. The emergency response communicator must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24-hours and automatically transmit a low battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to assure that the monitoring agency and the provider's equipment meets the following requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment. The monitoring agency's equipment must include the following:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;
- A back-up information retrieval system;
- A clock printer, which must print out the time and date of the emergency signal, the PERS individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- A back-up power supply;
- A separate telephone service;
- A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

Provider Documentation Requirements

1. The appropriate ISAR form, to be completed by the case manager, may serve as the ISP, provided it adequately documents the need for the service, the type of device to be installed and description of ongoing services, including training regarding the use of the PERS. The ISAR must be submitted to DMHMRSAS for authorization to occur (see "Exhibits" for sample forms);

2. A PERS provider must maintain a data record for each individual utilizing PERS at no additional cost to DMAS. The record shall document all of the following:

   - Delivery date and installation date of the PERS;
   - Individual/caregiver signature verifying receipt of PERS device;
   - The PERS device is operational as verified, minimally, by a monthly test;
   - Updated and current individual responder and contact information, as provided by the individual or the individual's care provider; and
   - A case log documenting individual system utilization and individual or responder contacts/communications.

3. The PERS provider shall document and furnish a written report to the case manager for each emergency signal, which results in action being taken on behalf of the individual. This shall exclude test signals or activations made in error.

RESPITE SERVICES (AGENCY-DIRECTED)

Service Definition

Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver. They are provided in an individual's home, other community residence or in other community sites.

Activities

The allowable activities include, but are not limited to:

1. Assistance with activities of daily living such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;

4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);

5. Assistance with housekeeping activities, such as bed-making, dusting and vacuuming, laundry, grocery shopping, etc., when specified in the individual's ISP and essential to the individual health and welfare;

6. Support to assure the safety of the individual;

7. Assistance or support, or both, needed by the individual to participate in social, recreational, or community activities; and

8. Accompanying the individual to appointments or meetings.

Criteria

Respite services may only be offered to individuals who have an unpaid primary caregiver living in the home who requires temporary relief to avoid institutionalization of the individual. Respite is designed to focus on the need of the caregiver for temporary relief and to help prevent the breakdown of the caregiver due to the physical burden and emotional stress of providing continuous support and care to the dependent individual.

Training of the individual is not expected with Respite services.

Respite services may not be provided by a DSS approved Adult Foster Care/Family Care providers to an individual residing in that setting.

The case manager may request a change in the amount of authorized hours for Respite services on the ISP at any time this is justified by individual need. (See "Authorization of Mental Retardation Waiver Services" in this chapter for details.)

Medicaid reimbursement is available only for Respite services provided when the individual is present and when a qualified provider is providing the Respite services.

If the provider is a DMAS enrolled Personal Care/Respite provider (provided that the following does not apply to DMHMRSAS licensed providers):

1. The designated supervisor must make an initial assessment visit prior to the start of Respite services for any individual admitted to Respite. The RN supervisor must also perform any subsequent reassessments or changes to the supporting documentation.

2. The supervisor must make supervisory visits as often as needed to ensure both quality and appropriateness of services.

    a. When Respite services are received on a routine basis, the minimum acceptable

frequency of these supervisory visits shall be every 30-90 days based on the needs of the individual.

b. When Respite services are not received on a routine basis, but are episodic in nature, the supervisor is not required to conduct a supervisory visit every 30-90 days. Instead, the supervisor must conduct the initial home visit with the respite assistant immediately preceding the start of services and make a second home visit within the respite service period.

c. When Respite services are routine in nature and offered in conjunction with Personal Assistance, the 30-90 day supervisory visit conducted for personal assistance may serve as the visit for Respite. However, the supervisor must document supervision of Respite services separately. For this purpose, the same individual record may be used with a separate section for Respite services documentation.

Inability of a Provider to Provide Services and Substitution of Assistants

When a respite assistant is absent and the provider has no other assistant available to provide services, the provider is responsible for ensuring that services continue to the individual within a reasonable amount of time.

1. If no other provider is available who can supply an assistant, the provider shall notify the individual or family and case manager so that they may find another available provider of the individual's choice.

2. If a provider cannot supply a respite assistant to render authorized services, the provider may either obtain a substitute assistant from another provider if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the individual's services to another provider. Under these circumstances, the following requirements apply:

    a. The preauthorized respite provider is responsible for providing the supervision for the substitute assistant.

    b. The preauthorized respite provider must obtain a copy of the respite assistant's daily records signed by the individual and the substitute assistant from the respite provider providing the substitute assistant. All documentation of services rendered by the substitute assistant must be in the individual's record. The documentation of the substitute assistant's qualifications must also be obtained and recorded in the personnel files of the preauthorized provider. The two providers involved are responsible for negotiating the financial arrangements of paying the substitute assistant.

    c. Only the preauthorized provider may bill DMAS for services rendered by the substitute assistant. The respite provider that has the authorization to provide services to the individual must contact the case manager to

determine if additional preauthorization is necessary.

3. Substitute assistants obtained from other providers may be used only in cases where no other arrangements can be made for individual Respite services coverage and may be used only on a temporary basis. If a substitute assistant is needed for more than two weeks, the case must be transferred to another respite provider that has the assistant capability to serve the individual or individuals.

Service Units and Service Limitations

The unit of service for Respite services is one hour. Respite services provided in any setting are limited to 720 hours per calendar year. Individuals who are receiving both consumer-directed and agency-directed Respite services cannot exceed 720 hours per calendar year combined.

When two individuals who live in the same home request Respite services, the provider will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. The amount of time for tasks which could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and the hours split between the individuals. (For example, individual "A" might have 3 hours for bathing, dressing and toileting, while individual "B" might have 2 hours for bathing and dressing. They would share the assistant's time that totals 4 hours for housekeeping, laundry and meal preparation. Therefore, individual "A's" weekly hours would total 5, while individual "B's" weekly hours would total 4). The number of hours that may be billed is limited to the total number of hours worked by the assistant. (In this example, the total hours billed would be 9.)

Provider Documentation Requirements

The provider's records must include the following:

1. Respite services must have an individual-focused ISP that reflects the results of an initial assessment (and subsequent reassessments as needed) and includes the activities that will be provided during the respite period and the approximate hours that will be allowed for each activity. A provider-designed ISP, the Provider Agency Plan of Care form (DMAS-97A in "Exhibits" at the end of this chapter), or the standard Respite ISP (see ISPs in "Exhibits" at the end of this chapter) may be used for this purpose.

2. Documentation indicating the dates and times of Respite services and the amount and type of service provided must be in the individual's record. The Aide Record form (DMAS-90) may be used for this purpose (see "Exhibits" at the end of this chapter). Any other format for documentation of hours of Respite services should be reviewed by DMHMRSAS staff prior to use.

3. The appropriate Individual Service Authorization Request (ISAR) form must be completed and submitted to the case manager with the ISP for authorization by

DMHMRSAS to occur (see "Exhibits" for sample forms). If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS provider agreement.

4. All correspondence to the individual, DMAS and DMHMRSAS.

5. Significant contacts made with the family, physicians, and all professionals concerning the individual.

6. If the service is being provided by a DMAS enrolled Personal Care/Respite provider (the following does not apply to DMHMRSAS licensed agencies), the supervising RN or LPN must document in a summary note following significant contacts with the respite assistant and during supervisory visits to the individual's home:

   a. Whether Respite services continue to be appropriate;

   b. Whether the supporting documentation is adequate to meet the individual's needs or changes are indicated in the plan;

   c. Any special tasks performed by the assistant (e.g., assistance with bowel/bladder programs, range of motion exercises, etc. See "Exhibits" for more details) and the assistant's qualifications to perform these tasks;

   d. The individual's satisfaction with the service;

   e. Any hospitalization or change in medical condition or functioning status;

   f. Other services received and the amount; and

   g. The presence or absence of the respite assistant in the home during the nurse's visit.

7. The individual's record must contain:

   a. The specific services delivered to the individual by the respite assistant and the individual's response;

   b. The arrival and departure time of the assistant, or individual if going out of the home, for Respite services;

   c. Comments or observations recorded about the individual. Assistant comments must include, at a minimum, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered; and

   d. Signature, time and dates shall not be placed in the record prior to the date that the services are delivered.

8. There must be a copy of the current DMAS-122 (Patient Information) form (see "Exhibits" at the end of this chapter) in the patient's record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

9. Quarterly reviews are not required, as this service is typically delivered on an intermittent basis. However, Respite providers should regularly communicate with the individual's case manager about service provision and related issues.

COMPANION SERVICES (AGENCY-DIRECTED)

Service Description

Companion services provide non-medical care, socialization, or support to adults. This service is provided in an individual's home or at various locations in the community.

Activities

The allowable activities include, but are not limited to:

1. Assistance or support with tasks such as meal preparation, laundry and shopping;

2. Assistance with light housekeeping tasks;

3. Assistance with self-administration of medication;

4. Assistance or support with community access and recreational activities; and

5. Support to assure the safety of the individual.

Criteria

In order to qualify for Companion services, the individual shall have demonstrated a need for assistance with light housekeeping, community access, medication self-administration or support to assure safety.

The provision of Companion services does not entail hands-on nursing care and is provided in accordance with a therapeutic goal in the ISP.

The provider must conduct an initial home visit prior to initiating companion services to document the efficacy and appropriateness of services and to establish a service plan for the individual. The provider must provide follow-up home visits to monitor the provision of services quarterly or as often as needed. The individual must be reassessed for eligibility for services annually.

The case manager may request a change in the amount of authorized hours for Companion services on the ISP at any time this is justified by individual need. (See "Authorization of Mental Retardation Waiver Services" in this chapter for details).

Medicaid reimbursement is available only for Companion services provided when the individual is present and when a qualified provider is providing the services.

Restrictions

Companion services are only available to adults, ages 18 and older.

Service Units and Service Limitations

Companion services must be billed on an hourly basis. The amount of Companion services time included in the CSP may not exceed eight hours per 24-hour day. When two individuals who live in the same home request Companion services, the provider will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as assistance with self-medication. The amount of time for tasks which could and should be provided for both individuals simultaneously (such as meal preparation, light housekeeping, laundry, shopping and community access) must be combined and the hours split between the individuals. (For example, individual "A" might have 5 hours per week for assistance with self-medication, while individual "B" might have 2 hours per week for the same task. They would share the companion's time that totals 22 hours for housekeeping, laundry, meal preparation and community access. Therefore, individual "A's" weekly hours would total 16, while individual "B's" weekly hours would total 13). The number of hours that may be billed is limited to the total number of hours worked by the companion. (In this example, a total of 29 hours would be billed).

A companion shall not be permitted to provide the care associated with ventilators, continuous tube feedings, or suctioning of airways.

Provider Documentation Requirements

1. Companion services must have an individual-focused ISP that reflects the results of an initial assessment (and subsequent reassessments as needed) and includes the specific assistance that will be provided during the ISP period and the approximate hours that will be allowed for each activity.

2. The appropriate Individual Service Authorization Request (ISAR) form must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see "Exhibits" for sample forms). If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS provider agreement.

3. Documentation indicating the dates and times of Companion services and the amount and type of service provided must be in the individual's record. The companion's documentation should also include weekly comments or observations about the individual's status and his or her response to services.

4. All correspondence to the individual, DMAS and DMHMRSAS.

5. There must be a copy of the current DMAS-122 (Patient Information) form (see "Exhibits" at the end of this chapter) in the record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

6. The Companion services supervisor must document in a summary note following significant contacts with the companion and quarterly home visits with the individual:

   a. Whether Companion services continue to be appropriate;

   b. Whether the plan is adequate to meet the individual's needs or changes are indicated in the plan;

   c. The individual's satisfaction with the service; and

   d. The presence or absence of the companion during the supervisor's visit.

7. The ISP must be reviewed by the provider and this review submitted to the case manager, at least quarterly with modifications made as appropriate. Quarterly review documentation must include any revisions to the ISP and also address the general status of the individual, significant events, and individual's or family's, or both, satisfaction with the services. The due date for the quarterly review is determined by the effective start date of the CSP and communicated to the provider by the case manager. A ten-day grace period is permitted.

SKILLED NURSING SERVICES

Service Definition

Skilled nursing services are available to individuals with serious medical conditions and complex health care needs, which require specific skilled nursing services ordered by a physician and which cannot be accessed under the *State Plan for Medical Assistance*. These

services must be necessary to enable an individual to live in a non-institutional setting in the community and cannot be provided by non-nursing personnel. Services are provided in an individual's home or community setting, or both, on a regularly scheduled or intermittent need basis.

Activities

The allowable activities include, but are not limited to:

1. Monitoring of an individual's medical status;

2. Administering medications and other medical treatment; or

3. Training or consultation with family members, staff, and other persons responsible for carrying out an individual's CSP to monitor the individual's medical status and to administer medications and other medically related procedures consistent with the Nurse Practice Act (Title 54.1, Code of Virginia, Subtitle III, Chapters 30 and 34).

Criteria

If an individual has skilled nursing needs that are short-term and intermittent in nature, the case manager must assist the individual in accessing skilled nursing services under the *State Plan for Medical Assistance*. The State Plan Home Health coverage provides short-term intermittent skilled nursing services for 32 visits without pre-authorization. It must be accessed through a licensed Home Health Agency that has a provider agreement with DMAS for skilled nursing services. Additional visits after the initial 32 visits require pre-authorization from DMAS.

If an individual has skilled nursing needs that are expected to be long-term in nature, the case manager may assist the individual in accessing skilled nursing services under the MR Waiver. The individual's CSP must state that this service is necessary in order to prevent or delay institutionalization.

The case manager is responsible for inquiring whether an individual is receiving Home Health services under the State Plan at the time that waiver services are initiated. If the individual receives Home Health services that are comparable to services available under the MR Waiver, the case manager must notify the individual and the Home Health provider. If the individual desires nursing services under the MR Waiver, the case manager must facilitate the transfer of the nursing services to the MR Waiver or identify another available provider of nursing services.

Skilled Nursing services under the MR Waiver are those procedures that cannot be provided by non-nursing personnel, consistent with the Commonwealth's Nurse Practice Act.

The case manager may request a change in the amount of authorized hours for Skilled Nursing services on the ISP at any time this is justified by individual need. (See "Authorization of Mental Retardation Waiver Services" in this chapter for details).

Medicaid reimbursement is available only for Skilled Nursing services provided when the individual is present (with the exception of family or staff consultation and training regarding the individual's medical needs) and when a qualified provider is providing the services.

Service Units and Service Limitations

The unit of service is one hour, with no limitation on the number of hours that may be authorized. However, the Skilled Nursing services must be explicitly detailed in an ISP and must be specifically ordered by a physician as medically necessary to prevent or delay institutionalization.

Provider Documentation Requirements

There must be:

1. An ISP that notes the specific nursing services to be provided and the estimated amount of time required to perform these services. A provider-designed ISP or the HCFA-485 form (available from the Centers for Medicare and Medicaid Services) may be used for this purpose (see the "Exhibits" section at the end of this chapter). The ISP must specify any training of family or staff, or both, to be provided, including the individual(s) of the training and content of the training (consistent with the Nurse Practice Act);

2. Initial, and, in subsequent years, annual documentation of medical necessity by a physician. This may be accomplished by having a physician sign the HCFA-485 form or provider-designed ISP. Alternatively, the physician may provide a statement, which specifies skilled nursing services required by the individual. The need for the skilled services of an RN or LPN must be specified as well as the number of nursing hours needed. This statement must be retained with the HCFA-485 form or ISP;

3. The appropriate ISAR form must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see the "Exhibits" section for sample forms). If, at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS provider agreement.

4. A copy of the current DMAS-122 (Patient Information) form (see the "Exhibits" section at the end of this chapter) in the record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

5. Documentation of nursing license/qualifications of providers;

6. Documentation indicating the dates and times of nursing services and the amount and type of service or training provided. It is suggested that the format for documentation of hours of services be reviewed by DMHMRSAS staff prior to use;
7. Documentation that changes to the ISP were ordered by a physician prior to implementation; and

8. An ISP that has been reviewed by the provider, and this review submitted to the case manager, at least quarterly with modifications made as appropriate. Quarterly review documentation must include any revisions to the ISP and also address the general status of the individual, significant events, and individual and family satisfaction with services. The due date for the quarterly review is determined by the effective start date of the CSP and communicated to the provider by the case manager. A ten-day grace period is permitted.

ENVIRONMENTAL MODIFICATIONS

Service Definition

Environmental Modifications are physical adaptations to an individual's home or community residence, vehicle, and, in some instances, a workplace, which provide direct medical or remedial benefit to the individual. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home or work site. Without these adaptations the individual would require institutionalization.

Modifications and Activities

Modifications and activities are:

1. Physical adaptations to a house or place of residence necessary to ensure an individual's health, welfare and safety (installation of specialized electric and plumbing systems to accommodate medical equipment and supplies, etc.);

2. Physical adaptations to a house or place of residence which enable an individual to live in a non-institutional setting and to function with greater independence that do not increase the square footage of the house or place of residence (e.g., installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities, etc.);

3. Environmental modifications to the work site (which exceed reasonable accommodation requirements of the employer under the Americans with Disabilities Act); and

4. Modifications to the primary vehicle being used by the individual.

Criteria

This service is available to individuals who are receiving at least one other MR Waiver service, along with Targeted MR Case Management Services.

The CSB/BHA case manager could possibly deal with three different providers in order to complete one modification, for example:

1. A Rehabilitation Engineer may be used to evaluate the individual's needs and subsequently act as project manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the Rehabilitation Engineer may actually design and personally complete the modification. A Physical Therapist or Occupational Therapist, available through the *State Plan for Medical Assistance* or MR Waiver Therapeutic Consultation, may also be utilized to evaluate the needs for environmental modifications. (NOTE: Under the *State Plan for Medical Assistance*, Physical and Occupational Therapy services must be preauthorized by DMAS if more than 24 visits have been provided to the individual. Visits are individual-specific, not provider-specific.);

2. A building contractor may design and complete the structural modification; and

3. A vendor who supplies the necessary materials may be separately reimbursed, or supplies may be included in the bill of the building contractor or Rehabilitation Engineer.

A Rehabilitation Engineer might be required if (for example):

- The environmental modification involves combinations of systems which are not designed to go together; or

- The structural modification requires a project manager to assure that the design and functionality meet ADA accessibility guidelines.

Service Units and Service Limitations

The service unit for Rehabilitation Engineering is hourly. Building contractor services are individually contracted for and may include supplies, or the total cost of supplies may be billed separately.

The maximum Medicaid-funded expenditure for environmental modifications is $5,000.00 per CSP year. Costs for environmental modifications cannot be carried over from one CSP year to the next, and must be pre-authorized each CSP year.

Exclusions to this service are those modifications, adaptations or improvements to the home which are of general utility and are not intended to provide a direct medical or remedial benefit to the individual (i.e. carpeting, roof repair, central air conditioning, etc.). Further, environmental modifications may not be used to bring a substandard dwelling up to minimum

habitation standards. Modifications, adaptations or improvements which add to the total square footage of the home shall be excluded.

Provider Documentation Requirements

The following documentation is required:

1. The appropriate ISAR form, to be completed by the case manager, may serve as the ISP, provided it adequately documents the need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of the evaluation, design, labor, and supplies or materials, or both. The ISP/ISAR must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved. The ISAR must be submitted to DMHMRSAS for authorization to occur (see the "Exhibits" section for sample forms);

2. Documentation of the date services are rendered and the amount of services and supplies;

3. Any other relevant information regarding the environmental modification;

4. Documentation of notification by the individual or individual's representative of satisfactory completion of the service; and

5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed.

ASSISTIVE TECHNOLOGY

Service Definition

Assistive Technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the *State Plan for Medical Assistance*, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning.

Equipment and Activities

The equipment and activities include:

1. Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the *State Plan for Medical Assistance*;

2. Durable or non-durable medical equipment and supplies (DME) not available under the *State Plan for Medical Assistance*;

3. Adaptive devices, appliances, and controls not available under the *State Plan for Medical Assistance* which enable an individual to be more independent in areas of personal care and activities of daily living; and
4. Equipment and devices not available under the *State Plan for Medical Assistance*, which enable an individual to communicate more effectively.

Criteria

This service is available to individuals who are receiving at least one other MR Waiver service, along with Targeted MR Case Management Services.

Assistive Technology may be provided in residential and non-residential settings. Items will not be approved for purposes of convenience of the caregiver or restraining the individual.

Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under the MR Waiver. A copy of the Durable Medical Equipment and Supplies list is available from DMAS and should be used to ascertain whether an item is covered through the *State Plan for Medical Assistance* before requesting it through the MR Waiver. All questionable items should be verified as covered items with the DMAS HELPLINE (804-786-5408 or 800-552-8627 or 800-852-6080) prior to billing.

Equipment and supplies must be purchased from a DME provider, if available. Any equipment, supplies, or technology not available through a DME provider may be purchased by the CSB/BHA and billed to DMAS for reimbursement.

Assistive Technology items must be recommended and determined appropriate to meet the individual's needs by the following professionals, prior to approval by DMHMRSAS:

Examples of Assistive Technology Devices (not a comprehensive list)	Professional Assessment Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/Software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces	Physical Therapist or Physician
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Handicapped Toilets	Occupational Therapist or Physical Therapist
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist or Occupational Therapist (depending on the device or equipment)

Specially Designed Utensils for Eating	Occupational Therapist or Speech Language Pathologist
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist Psychologist, or Behavioral Consultant

For items not included above, contact DMHMRSAS for assistance with determining the appropriate professional required to make the recommendation and determination.

A Rehabilitation Engineer may be utilized if, for example:

- The Assistive Technology will be initiated in combination with Environmental Modifications involving systems which are not designed to go together; or

- An existing device must be modified or a specialized device must be designed and fabricated.

Service Units and Service Limitations

The service unit for items and supplies is the total cost of the item and any supplies. The service unit for Rehabilitation Engineering is hourly.

The maximum Medicaid funded expenditure for Assistive Technology is $5,000.00 per CSP year. Assistive Technology shall be covered in the least expensive, most cost effective manner. The cost for Assistive Technology cannot be carried over from one CSP year to the next, and must be pre-authorized each CSP year.

Provider Documentation Requirements

The following documentation is required:

1. The appropriate ISAR form, to be completed by the case manager, may serve as the ISP, provided it adequately documents the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes a separate notation of evaluation or design, or both, labor, and supplies or materials, or both. The ISP/ISAR must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved. A Rehabilitation Engineer may be involved if disability expertise is required that a general contractor will not have. The ISAR must be submitted to DMHMRSAS for authorization to occur (see "Exhibits" for sample forms);

2. Written documentation regarding the process and results of ensuring that the item is not covered by the *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies and that it is not available from a DME provider when purchased elsewhere;

3. Documentation of the recommendation for the item by a qualified professional;

4. Documentation of the date services are rendered and the amount of service needed;

5. Any other relevant information regarding the device or modification;

6. Documentation in the case management record of notification by the designated individual or individual's representative of satisfactory completion or receipt of the service or item; and

7. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed.

DAY SUPPORT

Service Definition

Day Support services include training, assistance or specialized supervision for the acquisition, retention or improvement in self-help, socialization and adaptive skills. It allows peer interactions and an opportunity for community and social integration. Specialized supervision provides staff presence for ongoing or intermittent intervention to ensure an individual's health and safety.

These services typically take place in non-residential settings, separate from the home or facility in which the individual resides. Day Support services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech/language therapies listed in the CSP. In addition, day support services may serve to reinforce skills or lessons taught in school, therapy or other settings. Services shall normally be furnished 1 or more hours per day on a regularly scheduled basis for 1 or more days per week.

Services

The allowable Day Support services include, but are not limited to:

1. Functional training in self, social, and environmental awareness skills;

2. Functional training in sensory stimulation and gross and fine motor skills;

3. Functional training in communication and personal care;

4. Functional training in the use of community resources, community safety, appropriate peer interactions, and social skills;

5. Functional training in learning and problem-solving skills;

6. Functional training in adapting behavior to social and community settings;

7. Assistance with personal care and use of community resources;

8. Supervision to ensure the individual's health and safety;

9. Staff coverage for transportation of the individual between training and service activity sites; and

10. Opportunities to use functional skills in community settings.

Criteria

The case manager may request a change in the amount of authorized hours for Day Support services on the ISP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

Medicaid reimbursement is available only for Day Support services provided when the individual is present and when a qualified provider is providing the services.

Day Support services may only be suspended for an authorized individual if (1) the individual is receiving Behavioral or Psychological Consultation services and suspension is an agreed upon consequence stipulated in the individual's Support Plan, or (2) if the temporary removal of the individual from the Day Support site is necessary to ensure the health and safety of the individual or others within that setting. The provider should immediately notify the case manager in the event a suspension does take place so that the case manager can notify the individual of his/her right to appeal the action (see "Suspension of Waiver Services" later in this chapter).

60-Day Assessment

A functional assessment should be conducted to evaluate each individual in his or her Day Support environment or community setting, whichever is appropriate. A provider may use a 60-Day Assessment period while assessing the individual's need for specific training, assistance, specialized supervision, and support. If a provider utilizes an assessment period prior to developing an annual ISP, a preliminary ISP must be submitted to the case manager and must include the areas to be evaluated and a schedule of the services to be provided. The standard 60-Day Assessment ISP (see ISPs in the "Exhibits" section at the end of this chapter) may be used for this purpose. Prior to the last day of the assessment period, if the individual wishes the services to continue, the provider, with the involvement of the individual, must develop an annual ISP and forward it to the case manager for approval. The start date of the annual ISP would be no later than day 61 and would end when the annual CSP ends.

Types and Levels of Day Support

The amount and type of Day Support included in the individual's CSP is determined according to the level of staff involvement required for that individual. There are two types of Day Support: Center-based, which is provided partly or entirely in a single location with other individuals with disabilities, or Non-center-based, which is provided entirely in community

settings. Non-center-based Day Support services must be separate and distinguishable from either In-home/Supported Living Residential Support, or Personal Assistance services. There must be separate, supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. If the same record is used to document both services, each must be clearly differentiated in documentation and corresponding billing.

Both types of Day Support may be provided at either Intensive or Regular Levels. To be authorized at the Intensive Level, the individual must meet at least one of the following criteria:

- Requires physical assistance to meet the basic personal care needs (toileting, feeding, etc.);
- Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals; or
- Requires extensive personal care or constant supports to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program or behavioral objective in the ISP is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

Service Sites

Day Support cannot be regularly or temporarily (e.g., due to inclement weather or illness of the individual) provided in an individual's home or other residential setting without written, prior approval from DMHMRSAS. In this situation, the ISP must clearly indicate the specific time frame and designate specific Day Support activities provided in the individual's home or other residential setting. Examples of situations which may be exceptions to the prohibition against Day Support activities in the individual's home are:

- An individual's Day Support ISP includes allowable activities at the residential facility where the individual lives (e.g., learning or practicing skills related to grounds maintenance), provided this activity is not routinely performed by residents of the facility as part of their residential program;
- An individual is new to service or experiences serious emotional or behavior problems and requires a "phase-in period" to become accustomed to staff, a schedule and routine, riding in a van or car, etc. This phase-in period must be temporary with its expected duration clearly indicated on the Day Support ISP. During this "phase in period," only one (1) unit of Day Support services provided at the individual's home may be billed; and
- An individual returns from community settings to his or her residence for lunch. The "lunch location" and amount of time allotted for lunch must be specified on the Day Support ISP. A reasonable amount of time may be designated on the ISP for

eating lunch, including the associated preparation and clean-up. The majority of training related to meal preparation should occur within a Residential Support ISP.

Other Allowances

Individuals receiving Assisted Living services in an ALF *may* also receive Day Support services under the MR Waiver.

Service Units and Service Limitations

Billing is for a unit of service:

- One unit is 1 to 3.99 hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25% of the total time spent in the Day Support activity for that day.

- Two units are 4 to 6.99 hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25% of the total time spent in the Day Support activity for that day; and

- Three units are 7 or more hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25% of the total time spent in the Day Support activity for that day; however, a minimum of 7 hours of other allowable activities must be provided in order to be reimbursed for a 3-unit day.

The ISP must provide an estimate of the amount of Day Support required by the individual. The maximum is 780 units per CSP year.

Provider Documentation Requirements

The provider documentation requirements are:

1. An ISP consistent with DMHMRSAS licensing regulations.

2. The appropriate ISAR form must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see the "Exhibits" section at the end of this chapter for sample forms). If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or DMAS provider agreement.

3. There must be a copy of the current DMAS-122 (Patient Information) form (see the "Exhibits section at the end of this chapter) in the record. The provider must

clearly document efforts to obtain the completed DMAS-122 form from the case manager.

4. During a period when a 60-Day Assessment is used, documentation must confirm attendance or amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Assessment ISP objectives. The data/assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the 60-Day Assessment ISP. (For example, the ISP may prescribe that staff take traditional baseline data on a daily basis using a task analysis, scatter plot, or checklist format. Another individual's ISP might suggest a more informal approach to get to know the person in a variety of settings and activities, with this data/information collected in a more subjective, anecdotal fashion.) Assessment results should be available in at least a daily note or a weekly summary. Data should be collected as described in the ISP, analyzed, summarized, and then, clearly addressed in the regular ISP;

5. The ISP must be reviewed by the provider, and this review must be submitted to the case manager, at least quarterly, with goals, objectives, and activities modified as appropriate. Quarterly review documentation must include any revisions to the ISP and also address the general status of the individual, significant events, and individual or family, or both, satisfaction with services. The due date for the quarterly review is determined by the effective start date of the CSP and communicated to the provider by the case manager. A ten-day grace period is permitted;

6. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours and units provided (including specific time frame);

7. Documentation must be maintained to verify that billing for staff coverage during transportation (i.e., travel between the individual's home and the initial or final program site) does not exceed 25% of total time spent in Day Support on that day;

8. Documentation must indicate whether the services were Center-based or Non-center-based;

9. If high-intensity day support services are requested, in order to verify which of these criteria the individual met, documentation must be present in the individual's record to indicate the specific supports and the reasons they are needed. There must remain clear documentation of the ongoing needs and associated staff supports for high intensity day support services.

PREVOCATIONAL

Service Definition

Prevocational services are defined as services aimed at preparing an individual for paid or unpaid employment, but which are not job task-oriented. They are aimed at a more generalized result. Prevocational services are provided to individuals who are not expected to join the regular work force without supports or participate in a transitional sheltered workshop program within a year (excluding supported employment programs). Prevocational services may be provided in sheltered workshop settings.

Activities

The allowable activities include, but are not limited to:

1. Training and support in skills which are aimed at preparation for paid employment offered in a variety of community settings;

2. Training and support in activities that are primarily directed at habilitative goals (e.g., attention span and motor skills);

3. Training and support in such concepts as accepting supervision, attendance, task completion, problem solving and safety;

4. Training and support that is focused on completing assignments, solving problems, or safety;

5. Assistance with personal care;

6. Supervision to ensure the individual's health and safety; and

7. Staff coverage for transportation of the individual between training and service activity sites.

Criteria

In order to qualify for prevocational services, the individual shall have a demonstrated need for support in skills which are aimed towards preparation of paid employment which may be offered in a variety of community settings.

The case manager may request a change in the amount of authorized hours for Prevocational services on the ISP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

Medicaid reimbursement is available only for Prevocational services provided when the individual is present and when a qualified provider is providing the services.

Prevocational services may only be suspended for an authorized individual if (1) the individual is receiving Behavioral or Psychological Consultation services and suspension is an agreed upon consequence stipulated in the individual's Support Plan, or (2) if the temporary removal of the individual from the Prevocational site is necessary to ensure the health and safety of the individual or others within that setting. The provider should immediately notify the case manager in the event a suspension does take place so that the case manager can notify the individual of his/her right to appeal the action (see "Suspension of Waiver Services" later in this chapter).

Types and Levels of Prevocational Services

The amount and type of Prevocational services included in the individual's ISP is determined according to the level of staff involvement required for that individual. There are two types of Prevocational services: Center-based, which is provided partly or entirely in a single location with other individuals with disabilities, or Non-center-based, which is provided entirely in community settings. Non-center-based Prevocational services must be separate and distinguishable from either In-home/Supported Living Residential Support, or Personal Assistance services. There must be separate, supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. If the same record is used to document both services, each must be clearly differentiated in documentation and corresponding billing.

Both types of Prevocational services may be provided at either Intensive or Regular Levels. To be authorized at the Intensive Level, the individual must meet at least one of the following criteria:

- Requires physical assistance to meet the basic personal care needs (toileting, feeding, etc.);
- Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals; or
- Requires extensive personal care or constant supports to reduce or eliminate behaviors that preclude full participation in the program. A formal, written behavioral program or behavioral objective in the ISP is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

60-Day Assessment

A functional assessment should be conducted to evaluate each individual in his or her Prevocational environment or community setting, whichever is appropriate. A provider may use a 60-Day Assessment period while assessing the individual's need for specific training, assistance, specialized supervision, and support. If a provider utilizes an assessment period prior to developing an annual ISP, a preliminary ISP must be submitted to the case manager and must include the areas to be evaluated and a schedule of the services to be provided. The standard 60-Day Assessment ISP (see ISPs in the "Exhibits" section at the end of this chapter) may be used for this purpose. Prior to the last day of the assessment period, if the individual wishes the services to continue, the provider, with the involvement of the individual, must develop an annual ISP and forward it to the case manager for approval. The start date of the annual ISP would be no later than day 61 and would end when the annual CSP ends.

Prevocational services may be provided in either center-based settings or in the community at large.

Service Units and Service Limitations

Billing is for a unit of service:

- One unit is 1 to 3.99 hours of service a day. In instances where staff are required to ride with the individual to and from Prevocational activities, billing for this time cannot exceed 25% of the total time spent in the Prevocational activity for that day.

- Two units are 4 to 6.99 hours of service a day. In instances where staff are required to ride with the individual to and from Prevocational activities, billing for this time cannot exceed 25% of the total time spent in the Prevocational activity for that day; and

- Three units are 7 or more hours of service a day. In instances where staff are required to ride with the individual to and from Prevocational activities, billing for this time cannot exceed 25% of the total time spent in the Prevocational activity for that day; however, a minimum of 7 hours of other allowable activities must be provided in order to be reimbursed for a 3-unit day.

The ISP must provide an estimate of the amount of Prevocational services required by the individual. The maximum is 780 units per CSP year.

Vocational services may not be included in a MR Waiver Prevocational services plan for Medicaid reimbursement. Vocational services are job task-oriented with service activities primarily directed at teaching specific job skills. Examples of non-allowable vocational services include training focused on increasing productivity or teaching an individual to operate a specific type of equipment to perform a job, e.g., a floor buffer for a janitorial position.

Providers for persons eligible for or receiving Prevocational services funded under § 110 of the Rehabilitation Act of 1973 (through the Department of Rehabilitative Services) or § 602(16)&(17) of the Individuals with Disabilities Education Act (through special education services) cannot receive payment for this service through MR Waiver services. The case manager must assure that prevocational services are not available through these sources and document the finding in the individual's case management record. When services are provided through these sources, the CSP will not include them as a requested MR Waiver service.

Prevocational services are available only for persons whose compensation is less than 50% of minimum wage.

Documentation Requirements

1. An ISP is required, which must contain, at a minimum, the following elements:

    a. The individual's strengths; desired outcomes; required or desired supports, or both; and training needs;

    b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

    c. The services to be rendered and the frequency of services to accomplish the above goals and objectives;

    d. The person(s) or organization(s) that will provide the services specified in the statement of services;

    e. A timetable for the accomplishment of the individual's goals and objectives.

    f. The estimated duration of the individual's needs for services; and

    g. The person(s) responsible for the overall coordination and integration of the services specified in the plan;

Individuals who have heretofore received Prevocational services as a component of their Day Support services, may continue to do so under their Day Support ISP until 10/17/02. Providers of Prevocational services to these individuals may continue to bill these services under Day Support until that date as well. Individuals newly initiating receipt of Prevocational services and all individuals receiving these services after 10/17/02 must have a separate Prevocational ISP, ISAR, documentation and billing.

2. The appropriate ISAR form must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see the "Exhibits" section at the end of this chapter for sample forms). If at the annual review, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or the provicer's DMAS participation agreement.

3. There must be a copy of the current DMAS-122 (Patient Information) form (see the "Exhibits" section at the end of this chapter) in the record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

4. During a period when a 60-Day Assessment is used, documentation must confirm attendance or amount of time in services and provide specific information regarding the individual's response to various settings and supports as agreed to in the Assessment

ISP objectives. The data/assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the 60-Day Assessment ISP. (For example, the ISP may prescribe that staff take traditional baseline data on a daily basis using a task analysis, scatter plot, or checklist format. Another individual's ISP might suggest a more informal approach to get to know the person in a variety of settings and activities, with this data/information collected in a more subjective, anecdotal fashion.) Assessment results should be available in at least a daily note or a weekly summary. Data should be collected as described in the ISP, analyzed, summarized, and then, clearly addressed in the regular ISP.

5. The ISP must be reviewed by the provider, and this review must be submitted to the case manager, at least quarterly, with goals, objectives, and activities modified as appropriate. Quarterly review documentation must include any revisions to the ISP and also address the general status of the individual, significant events, and individual or family, or both, satisfaction with services. The due date for the quarterly review is determined by the effective start date of the CSP and communicated to the provider by the case manager. A ten-day grace period is permitted.

6. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours and units provided (including specific time frame).

7. Documentation must be maintained to verify that billing for staff coverage during transportation (i.e., travel between the individual's home and the initial or final program site) does not exceed 25% of total time billed from Prevocational services that day.

8. The lack of DRS or Special Education funding for the service must be documented in the record, as applicable. If the individual is older than 22 years, and, therefore, not eligible for Special Education funding, documentation is required only for lack of DRS funding. Acceptable documentation would include a copy of a letter from DRS or the local school system or a record of a phone call (the name, date, and person contacted) documented in the case manager's case notes, the Consumer Profile or Social Assessment, or on the annual Prevocational ISP. Unless the individual's circumstances change, the original verification can be forwarded into the current record or repeated on the ISP or revised Consumer Profile or Social Assessment on an annual basis.

SUPPORTED EMPLOYMENT

Service Definition

Supported Employment means work in settings in which persons without disabilities are typically employed. It is especially designed for individuals with developmental disabilities, including persons with mental retardation, facing severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential.

Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without on-going supports and who because of their disability, need ongoing post-employment support to perform in a work setting.

Activities

The allowable activities include, but are not limited to:

1. Individualized assessment and development of employment related goals and objectives;

2. Individualized job development for the individual's placement that produce an appropriate job match for the individual and the employer;

3. On-the-job training in work and work-related skills required to perform the job;

4. Ongoing evaluation, supervision, and monitoring of the individual's performance on the job which are required because of the individual's disabilities but which do not include supervisory activities rendered as a normal part of the business setting;

5. Ongoing support services necessary to assure job retention;

6. Training in related skills essential to obtaining and retaining employment, such as the effective use of community resources and break/lunch areas and transportation and mobility training; and

7. Staff coverage for transportation between the individual's place of residence and the workplace when other forms of transportation are unavailable or inaccessible.

Criteria

Models of Supported Employment

Supported Employment can be provided in one of two models. Individual Supported Employment is defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position who, during most of the time on the job site, performs independently. Group Supported Employment is defined as continuous support provided by staff to eight or fewer individuals with disabilities in an Enclave, Work Crew, Entrepreneurial model or Benchwork model. An Entrepreneurial model of Supported Employment is a small business employing fewer than eight individuals with disabilities and usually involves interactions with the public and with co-workers without disabilities. An example of the Benchwork model is a small, nonprofit electronics assembly business that employs individuals without disabilities to work alongside eight or fewer individuals with

significantly complex needs and provides daily opportunities for community integration. The individual's assessment and CSP must clearly reflect the individual's need for training and supports to acquire or maintain paid employment.

Restrictions with Other Services

Providers for persons eligible for or receiving prevocational services funded under §110 of the Rehabilitation Act of 1973 (through the Department of Rehabilitative Services) or § 602(16)&(17) of the Individuals with Disabilities Education Act (through special education services) cannot receive payment for this service through MR Waiver services. The case manager must assure that supported employment services are not available through these sources and document the findings in the individual's case management record. When services are provided through these sources, the CSP will not include them as a requested Waiver service. Supported Employment under the MR Waiver is usually a long-term service and is generally provided following time-limited DRS Supported Employment.

Only job development tasks that specifically include the individual are allowable job search activities under MR Waiver Supported Employment and only after determining this service is not available from DRS.

60-Day Assessment

A functional assessment should be conducted to evaluate each individual in his or her work environment and community settings. A provider may use a 60-Day Assessment period while assessing the individual's need for specific training, assistance, specialized supervision, and support. If a provider utilizes an assessment period prior to developing an annual ISP, a preliminary ISP must be submitted to the case manager, and include the areas to be evaluated and a schedule of services to be provided. The standard 60-Day Assessment ISP (see ISPs in the "Exhibits" section at the end of this chapter) may be used for this purpose. Prior to the last day of the assessment period, if the individual wishes the service to continue, the provider, with the involvement of the individual must develop and forward to the CSB/BHA case manager an annual ISP based upon the assessment information. The start date of the annual ISP would be no later than day 61 and would end when the annual CSP ends.

Other Criteria

The ISP must provide the amount of Supported Employment required by the individual. Service providers are reimbursed only for the amount and type of Supported Employment included in the individual's ISP.

The case manager may request a change in the amount of authorized hours for Supported Employment services on the ISP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

For the individual job placement model, reimbursement of Supported Employment will be limited to actual documented interventions or collateral contacts by the provider, not for the amount of time the individual is in the supported employment situation.

Supported Employment services may only be suspended for an authorized individual if (1) the individual is receiving Behavioral or Psychological Consultation services and suspension is an agreed upon consequence stipulated in the individual's Support Plan, or (2) if the temporary removal of the individual from the Supported Employment site is necessary to ensure the health and safety of the individual or others within that setting. The provider should immediately notify the case manager in the event a suspension does take place so that the case manager can notify the individual of his/her right to appeal the action (see "Suspension of Waiver Services" later in this chapter).

Service Units and Service Limitations

Supported Employment for individual job placement will be billed on an hourly basis. It may include transportation of the individual to and from work sites (not to exceed 25% of the total time billed).

Group models of Supported Employment (enclaves, work crews, Entrepreneurial and Benchwork models of Supported Employment) will be billed at the unit rate.

Units of service:

- One unit is 1 to 3.99 hours of service a day. In instances where staff are required to ride with the individual to and from Supported Employment activities, billing for this time cannot exceed 25% of the total time spent in the Supported Employment activity for that day.

- Two units are 4 to 6.99 or more hours of service a day. In instances where staff are required to ride with the individual to and from Supported Employment activities, billing for this time cannot exceed 25% of the total time spent in the Supported Employment activity for that day; and

- Three units are 7 or more hours of service a day. In instances where staff are required to ride with the individual to and from Supported Employment activities, billing for this time cannot exceed 25% of the total time spent in the Supported Employment activity for that day; however, a minimum of seven hours of other allowable activities must be provided in order to be reimbursed for a three-unit day.

Provider Documentation Requirements

The documentation requirements are:

1. Lack of DRS or Special Education funding for the service must be documented in the individual's record, as applicable. If the individual is older than 22 years, and, therefore not eligible for Special Education funding, documentation is required only for the lack of DRS funding. Acceptable documentation would include a copy of a letter from DRS or the local school system, or a record of a phone call (the name, date, and person contacted) documented in the case manager's case notes, Social Assessment, or

on the annual Supported Employment ISP. Unless the individual's circumstances change, the original verification can be forwarded into the current record or repeated on the ISP or revised Social Assessment on an annual basis.
As DRS is not responsible for "extended services" (or "follow along") in supported employment for people with mental retardation, documentation that an individual remains in extended services in supported employment with no change in circumstances would be sufficient. A change in circumstances, which might warrant a new verification of the lack of DRS funding, would include the loss of a Supported Employment placement or the need for a job change or upgrade, in which DRS-funded job development and initial on-the-job training could be available;

2. An ISP that contains, at a minimum, the following elements:

    a. The individual's strengths, desired outcomes, required or desired supports, and training needs;

    b. The individual's goals and, for a training goal, a sequence of measurable objectives to meet the above identified outcomes;

    c. The services to be rendered and the frequency of services to accomplish the above goals and objectives;

    d. The person(s) or organization(s) that will provide the services specified in the statement of services;

    e. A timetable for the accomplishment of the individual's goals and objectives;

    f. The estimated duration of the individual's needs for services; and

    g. The person(s) responsible for the overall coordination and integration of the services specified in the plan.

3. The appropriate ISAR form must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see "Exhibits" for sample forms). If at the annual review point, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or DMAS provider agreement.

4. There must be a copy of the current DMAS-122 (Patient Information) form (see "Exhibits" at the end of this chapter) in the record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

5. During the 60-day assessment period, documentation must confirm attendance and provide specific information regarding the individual's response to various settings and

supports as agreed to in the Assessment ISP objectives. The data/assessment information that is gathered may vary in type, intensity, methodology, and frequency according to the description in the 60-day Supported Employment Assessment ISP (e.g., the ISP may prescribe that staff take traditional baseline data on a daily basis using a task analysis, scatter plot, or checklist format. Another individual's ISP might suggest a more informal approach to get to know the person in a variety of settings and activities, with this data or information collected in a more subjective, anecdotal fashion.) Assessment results should be available in at least a daily note or weekly summary. Data should be collected as described in the ISP, analyzed, summarized, and then, clearly addressed in the regular ISP.

6. The provider must review the annual ISP, and this review must be submitted to the case manager, at least quarterly, with goals, objectives, and activities modified as appropriate. Quarterly review documentation must include any revisions to the ISP and also include the general status of the individual, significant events, and individual or family satisfaction with services. The due date for the quarterly review is determined by the effective start date of the CSP, with a ten-day grace period permitted;

7. An attendance log or similar document must be maintained which indicates the date, type of services rendered, and number of hours or units provided (including the specific time frame); and

8. Documentation must be maintained to verify that billing for staff coverage during transportation of the individual to and from work sites does not exceed 25% of total time billed for Supported Employment for that day.

THERAPEUTIC CONSULTATION

Service Definition

Therapeutic Consultation provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are:

1. Psychology;

2. Behavioral Consultation;

3. Therapeutic Recreation;

4. Speech and Language Pathology;

5. Occupational Therapy;

6. Physical Therapy; and

7. Rehabilitation Engineering.

Activities

Simple accommodations or modifications that may better support the individual may be identified merely by observing the individual's environment, daily routines and personal interaction, thereby eliminating the need for further, more complex interventions. If further assistance is needed by a Therapeutic Consultant, the allowable activities are:

1. Interviewing the individual, family members, caregivers, and relevant others to identify issues to be addressed and desired outcomes of consultation;

2. Observing the individual in daily activities and natural environments;

3. Assessing the individual's need for an assistive device or modification and/or adjustment in the environment or services;

4. Developing data collection mechanisms and collecting baseline data;

5. Observing and assessing current interventions, support strategies, or assistive devices being used with the individual;

6. Designing a written Support Plan detailing the interventions, environmental adaptations, and support strategies to address the identified issues and desired outcomes; this may include recommendations related to specific devices, technology or adaptation of other training programs or activities;

7. Demonstrating specialized, therapeutic interventions, individualized supports, or assistive devices;

8. Training family/caregiver and other relevant persons to assist the individual in using an assistive device, to implement specialized, therapeutic interventions or adjust currently utilized support techniques;

9. Training relevant persons to better support the individual simply by observing the individual's environment, daily routines and personal interactions; and

10. Reviewing documentation and evaluating the efficacy of assistive devices or the activities and interventions identified in the Support Plan.

Criteria

The individual's ISP must clearly reflect the individual's needs, as documented in the social assessment, for specialized consultation provided to caregivers in order to implement the CSP effectively. As with any MR Waiver service, this ISP must be submitted to the case manager for approval and authorization by DMHMRSAS prior to implementation.

The case manager may request a change in the amount of authorized hours for Therapeutic Consultation services on the ISP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

MR Waiver Therapeutic Consultation services may not include direct therapy provided to Waiver individuals, nor duplicate the activities of other services that are available to the individual through the *State Plan for Medical Assistance*.

Only Behavioral Consultation may be provided in the absence of other MR Waiver services.

It is recommended that a supervisory staff person at the receiving provider participate in the Therapeutic Consultation, so that, in the event of staff turnover, the consultation and Support Plan can be shared with new staff, and additional Therapeutic Consultation is not requested. The provider or family may request additional Therapeutic Consultation, if needed.

Service Units and Service Limitations

The unit of service is one hour, with no limitation on the number of hours that may be authorized. However, the services must be explicitly detailed in an ISP. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic Consultation may not be billed solely for purposes of monitoring.

Provider Documentation Requirements

The documentation requirements are:

1. ISP for Therapeutic Consultation. The standard Therapeutic Consultation ISP (see ISPs in "Exhibits" at the end of this chapter) may be used for this purpose. This must contain:

    a. Identifying Information. The individual's name and Medicaid number; provider name and provider number; responsible person and telephone number; effective dates for the ISP; and quarterly review dates, if applicable;

    b. Targeted objectives or time frames or expected outcomes;

    c. Specific consultation activities (frequency; where; when; and to whom); and

    d. The expected products (minimally, a written Support Plan detailing the interventions or support strategies).

2. Contact notes

    a. Date, location, and time of each consultative service contact;
    b. Type of activities and hours of service provided; and

c. Persons to whom activities were directed.

or

Monthly notes

a. Summary of consultative activities for the month;

b. Dates, locations, and times of service delivery;

c. ISP objective(s) addressed;

d. Specific details of the activities;

e. Services delivered as planned or modified; and

f. Effectiveness of the strategies and individual's and caregivers' satisfaction with the service.

3. The appropriate ISAR form must be completed and submitted to the case manager with the ISP for authorization by DMHMRSAS to occur (see "Exhibits" for sample forms). If at the annual review point, a new ISAR is not required (i.e., no change in level of service), the provider must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or DMAS provider agreement.

4. There must be a copy of the current DMAS-122 (Patient Information) form (see the "Exhibits" section at the end of this chapter) in the record. The provider must clearly document efforts to obtain the completed DMAS-122 form from the case manager.

5. Quarterly reviews are required of the service provider if consultation extends three months or longer and must be forwarded to the case manager with goals, objectives, and activities modified as appropriate. Quarterly review documentation must include:

   a. Any revisions to the Therapeutic Consultation ISP;

   b. Activities related to the therapeutic consultation supporting documentation;

   c. Individual status and satisfaction with services; and

   d. Consultation outcomes or effectiveness of the Support Plan.

   The due date for the quarterly review is determined by the effective start date of the CSP which is communicated to the provider by the case manager. A ten-day grace period is permitted. If consultation services extend less than three months, the provider

must forward contact notes, monthly notes, or a summary of such to the case manager for the Case Management quarterly review;

6. A written Support Plan, detailing the interventions and strategies for staff, family, and caregivers to use to better support the individual in the service; and

7. The Final Disposition Summary is forwarded to the case manager within 30 days following the end of the service and must include:

    a. Strategies utilized;

    b. Objectives met;

    c. Unresolved issues; and

    d. Consultant recommendations.

CRISIS STABILIZATION SERVICES

Service Definition

Crisis Stabilization is direct intervention (and may include one-to-one supervision) to persons with mental retardation who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. The goal is to provide temporary intensive services and supports to avert emergency psychiatric hospitalization or institutional admission or to prevent other out-of-home placement. The intent is to stabilize the individual and to strengthen the current living situation so the individual can be maintained during and beyond the crisis period.

Activities

The allowable activities include, but are not limited to:

1. Psychiatric, neuropsychiatric, and psychological assessment, and other functional assessments and stabilization techniques;

2. Medication management and monitoring;

3. Behavior assessment and positive behavior support;

4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;

5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community; and

6. Temporary Crisis Supervision (as a separate billable service) to ensure the safety of the individual and others.

Criteria

Crisis Stabilization services may not be used for continuous long-term care. Room and board and general supervision are not components of this service.

Assessment of Need

The individual must meet at least one of the following criteria:

a. Is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning;

b. Is experiencing extreme increase in emotional distress;

c. Needs continuous intervention to maintain stability; or

d. Is causing harm to self or others.

The individual must be at risk of at least one of the following:

a. Psychiatric hospitalization;

b. Emergency ICF/MR placement;

c. Disruption of community status (living arrangement, day placement, or school); or

d. Causing harm to self or others.

Crisis Stabilization services may only be authorized following a documented face-to-face assessment conducted by a qualified mental retardation professional (as defined in Chapter II of this manual under provider qualifications for Crisis Stabilization services). If appropriate, the assessment will be conducted jointly with a licensed mental health professional or other appropriate professional(s), or both. The actual service units per episode will be based on the documented clinical needs of the individual being served. Extension of services, beyond the 15-day limit per authorization, must be authorized following a documented face-to-face reassessment conducted by a qualified mental retardation professional. If appropriate, the reassessment will be conducted jointly with a licensed mental health professional or other appropriate professional(s), or both.

The case manager may request a change in the amount of authorized hours for Crisis Stabilization services on the ISP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

Allowable Settings

MR Crisis Stabilization services may be provided directly in, but not limited to, the following settings:

a. The home of an individual who lives with family or other primary caregiver(s);

b. The home of an individual who lives independently or semi-independently to augment any current services and support;

c. A community-based residential program to augment current services and supports;

d. A day program or setting to augment current services and supports; and, or all of the settings in this list; or

e. A respite setting to augment current services and supports.

Crisis Supervision

Crisis Supervision may be provided as a component of this service only if clinical or behavioral interventions allowed under this service are also provided during the authorized period.

Crisis Supervision must be provided one-to-one and face-to-face with the individual. It may be provided by the same provider of Crisis Stabilization Clinical or Behavioral services or a different provider.

Service Units and Service Limitations

Mental Retardation Crisis Stabilization Clinical or Behavioral services are billed in hourly service units and may be authorized for provision during a maximum of 15 days. Service can be provided no more than 60 days in a calendar year.

Crisis Supervision, if provided within the authorized period as a component of this service, is separately billed in hourly service units.

Provider Documentation Requirements

The documentation must contain:

1. The need for service or extension of service which must be clearly documented following a documented face-to-face assessment or reassessment, or both, by a qualified mental retardation professional;

2. A Crisis Stabilization ISP and ISAR which must be developed (or revised, if requesting an extension) and submitted to the case manager for submission to DMHMRSAS within 72 hours of the requested start date for authorization by DMHMRSAS to occur. The standard Crisis Stabilization ISP (see ISPs in "Exhibits" at the end of this chapter) may be used for this purpose;

3. Documentation indicating the dates and times of Crisis Stabilization services and the amount and type of service provided which must be in the individual's record; and

4. Documentation of the qualifications of providers which must be maintained for review by DMHMRSAS or DMAS staff.

CONSUMER-DIRECTED SERVICES

There are three Consumer-Directed (CD) services available under the MR Waiver. These are CD Personal Assistance (PA), CD Respite and CD Companion. The individual is the employer in these services and, as such, is responsible for hiring, training, supervising, and firing assistants or companions. If the individual is unable to independently manage his or her own consumer-directed services or if the individual is under 18 years of age, a family member/caregiver must serve as the employer on behalf of the individual.

No more than two individuals who live in the same home are permitted to share the authorized work hours of the assistant or companion within any given employee's shift. When two individuals who live in the same home request Consumer-Directed services, the Consumer-Directed (CD) Services Facilitator will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks which must be provided independently, such as bathing, dressing, ambulating, etc. The amount of time for tasks which could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and the hours split between the individuals. (For example, individual "A" might have 3 hours for bathing, dressing and toileting, while individual "B" might have 2 hours for bathing and dressing. They would share the assistant's/companion's time that totals 4 hours for housekeeping, laundry and meal preparation. Therefore, individual "A's" weekly hours would total 5, while individual "B's" weekly hours would total 4.) The number of hours that may be billed is limited to the total number of hours worked by the assistant or companion. (In this example, a total of 9 hours would be billed.)

Specific duties of the individual (or individual's family member/caregiver serving on behalf of the individual) regarding the assistant or companion include checking references, determining that the employee meets basic qualifications, training, supervising performance, and submitting timesheets to the fiscal agent on a consistent and timely basis. Unlike agency-directed services, consumer-directed assistants and companions are not eligible for Worker's Compensation.

The individual must have a back-up plan (e.g., a family member, neighbor or friend willing and available to assist the individual) in case the assistant or companion is unable to work as expected or terminates employment without prior notice. This is the responsibility of the individual and family and must be identified in the ISP. Individuals who do not have a back-up plan are not eligible for these services until they have developed one.

An individual may receive Consumer-Directed services along with any other MR Waiver service for which he/she is eligible, unless specifically prohibited. However, individuals cannot simultaneously (same billable hours) receive multiple services.

All Consumer-Directed services require the services of a Fiscal Agent (currently DMAS) and CD Services Facilitator (DMAS-enrolled provider) and must be preauthorized by DMHMRSAS. The CD Services Facilitation is not a Waiver service and does not require an ISP, ISAR or prior authorization by DMHMRSAS.

CD Services Payments

The Fiscal Agent will perform certain tasks as an agent for the individual who is receiving consumer-directed services (as the employer of the assistant or companion). The Fiscal Agent will provide a packet of employment information and necessary forms to the individual or family member/caregiver. The forms must be completed and returned to the Fiscal Agent before the assistant or companion can be employed. The Fiscal Agent will handle responsibilities for the individual for paying the assistant or companion and the related employment taxes.

CD Services Facilitator Responsibilities

1. Comprehensive Visit: Upon being selected by the individual or family member/caregiver, the CD Services Facilitator must make an initial comprehensive home visit for the purpose of identifying, with the individual or family member/caregiver, all individual needs to be addressed in the ISP. This must occur prior to the start of services for any individual choosing to receive consumer-directed services.

   The CD Services Facilitator will also provide the individual with a copy of the Employee Management Manual (see the "Exhibits" section at the end of this chapter). The CD Services Facilitator will ensure that the individual understands his or her rights and responsibilities in the program and signs all of the participation agreements found in the Employee Management Manual (with the Selection of Service, Fiscal Agent, and CD Services Facilitator). These forms must be signed before the individual can begin employing assistants or companions in the program. The CD Services Facilitator shall send a copy of the Fiscal Agent agreement to the Fiscal Agent and keep all originals for the individual's file.

The initial comprehensive visit is done only once upon the individual's entry into the service. If an individual changes CD Service Facilitator, the new provider must bill for a reassessment visit in lieu of a comprehensive visit.

2. Development of the Consumer-Directed Services ISP: The information gathered during the comprehensive visit should result in the development of the ISP for the appropriate consumer-directed service(s) for the individual. A copy of this ISP, along with a summary of the information gathered from the comprehensive visit, and the required ISAR will be forwarded to the case manager by the CD Services Facilitator to initiate the authorization process.

3. Employee Management Training: The CD Services Facilitator, using the Employee Management Manual, must provide the individual with training on his or her responsibilities as employer within seven days of receipt of the authorization of the CD PA, Respite or Companion services (CD Services Facilitators can complete the comprehensive visit and individual training in the same day, if appropriate). To assure that the training content for Employee Management Training meets the acceptable requirements, the CD Services Facilitator must use, at a minimum, the curriculum provided by DMAS in the "Exhibits" section at the end of this chapter. Regardless of the method of training received, documentation must be present indicating the training has been received prior to the individual's employing an assistant or companion.

4. Routine Onsite Visits: After the comprehensive visit, the CD Services Facilitator must conduct two onsite, routine visits within 60 days of the authorization of CD services (once per month) to monitor and ensure both the quality and appropriateness of the services being provided. After the first two routine onsite visits, the CD Services Facilitator and individual can decide how frequent the routine onsite visits will be. However, a face-to-face meeting with the individual must be conducted at least every six months to ensure appropriateness of services. These meetings should include times when services are scheduled to be delivered. The CD Services Facilitator must record all significant contacts in the individual's file.

   During visits to the individual's home, the CD Services Facilitator must consult with the individual or family member/caregiver or both to evaluate and document the adequacy and appropriateness of the consumer-directed services. If a health and safety issue is noted by the CD Services Facilitator during a visit, he/she is obligated to report this to the case manager and Child Protective Services/Adult Protective Services, as appropriate.

   The CD Services Facilitator's documentation of this visit may be in the form of a progress note or a standardized form. The "Exhibits" section at the end of this chapter contains an example of the Consumer-Directed Services Assessment Report (DMAS-99B) (available on the DMAS website under form for "Consumer Directed Personal Attendant Services"). The CD Services Facilitator must document:

- Whether consumer-directed services are adequate to meet the individual's needs and whether changes need to be made;
- Hospitalization or change in medical condition, functioning, or cognitive status;
- The individual's and/or family member's/caregiver's (as appropriate) satisfaction with services;
- The presence or absence of the assistant or companion in the home during the visit;
- Any change in who is employed as the assistant or companion. The CD Services Facilitator must note this in the individual's file and ensure that the criminal history record check (and Child Protective Services Registry as appropriate) is performed on this new employee;
- A review of time sheets. The CD Services Facilitator must review the personal assistant's/companion's time sheets, which are submitted to the fiscal agent by the individual or family member/caregiver, to determine whether the assistant/companion and individual or family member/caregiver are recording the approved number of hours (see number 11 below); and
- In addition to the typical information that must be documented in the CD Services Facilitator's routine visit summary, there are several areas (such as bowel/bladder programs, range of motion exercises, catheter and wound care) that, when they are part of an individual's ISP due to physician's orders, require monitoring by a registered nurse and special documentation by the CD Services Facilitator (see the "Exhibits" section at the end of this chapter for more details.).

5. Availability: The CD Services Facilitator must be available by telephone to the individual receiving CD services.

6. Attendance at Meetings: If requested by the individual, the Services Facilitator will attend CSP meetings. If the individual does not request a meeting, but the CD Services Facilitator has questions about the services that have been designated in the individual's CSP/ISP, the CD Services Facilitator, with the permission of the individual, may contact the case manager to discuss the issues.

7. Update Visit: Annually, the CD Services Facilitator must meet with the individual or family member/caregiver to review the individual's current medical, functional, and social support status, as related to consumer-directed services, provide the information to the case manager, and work together with the case manager to develop the annual ISP. The first annual update visit may be less than 12 months from the comprehensive visit, as the CD services must comply with the case manager's stated quarterly review and annual ISP review schedule.

Additionally, the CD Services Facilitator should conduct an update visit for individuals who are transferring from another CD Services Facilitator or who request a change in their CD services.

8. Monitoring: The CD Services Facilitator is responsible for taking appropriate action to assure continued appropriate and adequate service to the individual. Appropriate actions may include: counseling or training an assistant or companion about the services to be provided to the individual (at the individual's request); counseling or training an individual regarding his or her responsibilities as an employer; submitting any changes in the ISP to the case manager, following consultation with the individual or family member/caregiver as needed; and discussing with the individual the need for additional Consumer-Directed services. Any time the CD Services Facilitator is unsure of the action that needs to be taken, he or she should contact the case manager.

9. Management Training: This training is provided by the CD Services Facilitator upon the request of the individual or family member/caregiver. This may be additional management training for the individual or family member/caregiver or special training for the assistant or companion at the request of the individual. CD Services Facilitators can provide up to four hours of management training on behalf of an individual or family member/caregiver within any six-month period. Each hour of management training is billed as one unit. Management training can also be used to reimburse the CD Services Facilitator for the costs of tuberculosis skin tests, cardiopulmonary resuscitation certification, and annual flu immunizations required of personal and respite assistants. CD Services Facilitators providers can bill DMAS for the costs of these requirements on behalf of the individual by billing for these costs in Management Training units and maintaining documentation of these costs in the individual's file.

10. Criminal Record Check: All consumer-directed assistants and companions must complete a criminal record check. CD Services Facilitators assist individuals by submitting the criminal record check forms on the assistant or companion to the Virginia State Police on behalf of the individual prior to the start of CD services and whenever the individual hires a new assistant or companion. CD Services Facilitators will also pay the $15.00 fee for a criminal record check on behalf of the individual, and DMAS will reimburse CD Services Facilitators for the cost of the criminal record check for up to six record checks per individual within any six month period of time. The CD Services Facilitator will provide the individual or family member/caregiver with the results of the criminal history record request and document in the individual's record that the individual or family member/caregiver has been informed of the results of the criminal record check. If the assistant or companion has been convicted of crimes described in §37.1-183.3 of the Code of Virginia or the assistant or companion has a confirmed record on the DSS Child Protective Services Registry, the assistant or companion will no longer be reimbursed under this program for services provided to the individual effective the date the criminal record was confirmed. The CD Services Facilitator is responsible for notifying the Fiscal Agent whenever an assistant or

companion is found to have been convicted of any of the applicable crimes. (See the "Exhibits" section at the end of this chapter for a listing of applicable crimes).

If the assistant is providing CD-PA or CD-Respite services to an individual under 18 years of age, the assistant must be screened through the DSS Child Protective Services Registry. If the registry confirms a complaint on the assistant, the assistant will no longer be reimbursed under this program for services provided to the individual effective as of the date the child protective services registry was confirmed.

Individuals have the right to choose, hire and employ an assistant or companion whom they know has been convicted of a crime that is not prohibited in the applicable sections of the Code (12 VAC 32.1-162.9:1), as may be amended from time to time sections of the Code. When doing so, individuals and family members/caregivers must understand this decision and that the consequences thereof are their sole responsibility. In making this decision, individuals or family members/caregivers must sign Appendix F in the Employee Management Manual, "Consumer/Employment Acceptance of Responsibility for Employment," in which the individual agrees by employing the assistant or companion to hold harmless from any claims and responsibility DMAS, the CD Services Facilitator, and the Fiscal Agent. This form must be kept in the individual's file.

11. Verification of timesheets: The CD Services Facilitator shall relay the completed DMAS-122 (and subsequent updates) received from the case manager to the Fiscal Agent for use in processing time sheets. The CD Services Facilitator shall review copies of the timesheets during routine onsite visits to ensure that the hours of service provided are consistent with the ISP. If the individual is unable to sign the time and no other family member/caregiver is able to sign, the individual may make an "X." If the individual is unable to sign or make an "X," the CD Services Facilitator must make a notation in the front of the individual's record that "individual is unable to sign."

    If discrepancies are identified in the timesheets, the CD Services Facilitator must contact the individual or family member/caregiver to resolve discrepancies and must notify the Fiscal Agent. If an assistant or companion consistently has discrepancies in his or her timesheets and training has been offered, the CD Services Facilitator must meet with the individual or family member/caregiver and case manager to determine if CD services remain appropriate (i.e., that the individual or family member/caregiver can manage the services).

12. Assistant and Companion Registry: The CD Services Facilitator shall maintain an assistant and companion registry. The registry shall be a list that contains the names of persons who have experience with providing Personal Assistance, Companion or Respite services or who are interested in providing CD Respite, CD-PA or CD Companion services. The registry shall be maintained as a supportive source for the individual who may use the registry to obtain the names of potential assistants or

companions. DMAS does not require CD Services Facilitators to verify an assistant's or companion's qualifications prior to enrollment in a registry.

Required CD Services Facilitation Documentation

The CD Services Facilitator must maintain records for each individual served. At a minimum these records must contain:

1. All copies of the CD Services ISP that reflects the results of the CD Service Facilitator's initial comprehensive visit (and subsequent reassessment visits, as needed) and includes the types of assistance (allowable activities) that will be provided during the ISP period and the approximate hours;

2. The appropriate Individual Service Authorization Request (ISAR) form, completed by the CD Services Facilitator and submitted to the case manager (along with the ISP and comprehensive or update visit summary) for authorization by DMHMRSAS (see the "Exhibits" section at the end of this chapter for sample forms). The start date on the ISAR will be the start date of service facilitation services for the individual. If at the annual review, a new ISAR is not required (i.e., no change in level of service), the CD Services Facilitator must still ensure that the case manager receives a copy of the revised ISP prior to its due date. Failure to do so could jeopardize the provider's ability to bill for services or provider's DMAS participation agreement;

3. All DMAS-122 forms [Note: if Consumer-Directed services are the only services an individual is receiving and that individual is assigned a patient pay, the patient pay amount is to be deducted from the assistant's or companion's Medicaid reimbursement and the individual is responsible for paying the patient pay amount directly to the assistant or companion.] The CD Services Facilitator must clearly document efforts to obtain the completed DMAS-122 form from the case manager;

4. A Consent to Exchange Information Form (DMAS-20), authorizing release and communication of confidential information to related providers;

5. CD Services Facilitation notes recorded and dated documenting any contacts with the individual and family member/caregiver as applicable and visits to the individual's home;

6. All correspondence to the individual and family member/caregiver, the case manager, and to DMHMRSAS;

7. Updates to information about the individual made during the provision of services;

8. Records of contacts made with family, physicians, DMAS, formal and informal service providers and all professionals concerning the individual;

9. All training provided to the assistant or companion on behalf of the individual or family member/caregiver;

10. All management training provided to the individual or family member/caregiver, including the individual's or family member's/caregiver's responsibility for the accuracy of the assistant's or companion's timesheets;

11. All documents signed by the individual or the family member/caregiver that acknowledge the responsibilities of the services;

12. The CD PA and Companion services ISP which must be reviewed by the CD Services Facilitator and this review submitted to the case manager, at least quarterly, with modifications made, as appropriate. Quarterly review documentation must include any revisions to the ISP and also address the general status of the individual, significant events, and individual or family member's/caregiver's, or both, satisfaction with services. The due date for the quarterly review is determined by the effective start date of the CSP and communicated to the CD Services Facilitator by the case manager.

    A quarterly review is not required for CD Respite services. However, the CD Services Facilitator will review the utilization of and individual or family member/caregiver satisfaction with CD Respite either every six months or upon the use of 300 respite hours, whichever comes first. This review must be submitted to the case manager.

See the section titled "Requests for Billing Materials and All Forms Used by Provider Agencies" in Chapter V regarding the ordering of forms.

Although the services of the CD Services Facilitator do not require pre-authorization, all criteria and documentation requirements must be met for the entire time the service is provided in order to be reimbursed under the MR Waiver.

COMPANION SERVICES (CONSUMER-DIRECTED)

Service Definition

Companion services provide non-medical care, socialization or support to adults. This service is provided in an individual's home or at various locations in the community.

Activities

The allowable activities include, but are not limited to:

1. Assistance or support with tasks such as meal preparation, laundry and shopping;

2. Assistance with light housekeeping tasks;

3. Assistance with reminders for self-administration of medication;

4. Assistance or support with community access and recreational activities; and

5. Support to assure the safety of the individual.

Criteria

In order to qualify for CD Companion services, the individual must demonstrate a need for assistance with instrumental activities of daily living, light housekeeping, community access, medication self-administration, or support to assure safety, during times when no other supporting individuals are available.

The provision of Companion services does not entail hands-on nursing services and is provided in accordance with a therapeutic goal in the ISP.

The case manager may request a change in the amount of authorized hours for Companion Support services on the CSP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

Medicaid reimbursement is available only for Companion services provided when the individual is present and when a qualified provider is providing the services.

Restrictions

Companion services are available to adults only, age 18 and older.

Transportation

The companion may transport the individual in the individual's primary vehicle or accompany the individual in order to implement the individual's ISP. The companion may drive the individual only in the individual's primary vehicle, if all of the following criteria are met:

- The total time required by the companion for the day, including the time required to drive the individual, does not exceed the individual's weekly authorized hours. If the total time required exceeds the daily hours, the additional time may be deducted from another day in that week as long as this does not jeopardize the individual's health and safety;

- The vehicle is registered in the Commonwealth of Virginia;

- The owner of the vehicle has current automotive insurance containing collision, comprehensive, and liability coverage with a minimum of 100-300-50. The insurance must insure the individual and cover the companion as a driver of the vehicle;

- The companion has a valid Virginia driver's license; and
- The performance of this service is necessary to implement the individual's ISP.

Service Units and Service Limitations

Companions are paid an hourly rate. Companions are paid by the Fiscal Agent on behalf of the individual once the timesheet is signed by the companion and the individual and forwarded to the Fiscal Agent. The timesheet is sent to the Fiscal Agent (with a copy kept for the CD Services Facilitator) by the individual or family member/caregiver biweekly.

Companion services must be billed on an hourly basis. The amount of Companion services time included in the ISP may not exceed eight hours per 24-hour day.

A companion shall not be permitted or reimbursed to provide the care associated with ventilators, continuous tube feedings, or suctioning of airways.

Provider Documentation Requirements

Documentation must clearly indicate the dates and times of Companion services delivery (i.e., timesheets).

PERSONAL ASSISTANCE SERVICES (CONSUMER-DIRECTED)

Service Definition

Consumer Directed Personal Assistance (CD-PA) services mean direct assistance with personal care activities of daily living, access to the community, medication and other medical needs and monitoring health status and physical condition. When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) which are incidental to the Personal Assistance services furnished, or which are essential to the health and welfare of the individual. CD-PA services shall not include either practical or professional nursing services as defined in the Nurse Practice Act. CD-PA services may be provided in the home or community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities.

Activities

The allowable CD-PA Services include, but are not limited to:

1. Assistance with activities of daily living (ADLs) such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.;
2. Assistance with monitoring health status and physical condition;
3. Assistance with self–administration of medication and other medical needs;

4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);

5. Assistance with housekeeping activities, such as bed making, dusting, and vacuuming, laundry, grocery shopping, etc., when specified in the individual's ISP and essential to the individual's health or welfare, or both;

6. General support to assure the safety of the individual;

7. Assistance and support needed by the individual to participate in social, recreational or community activities;

8. Assistance with bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and external catheter care (see the "Exhibits" section at the end of this chapter for more details);

9. Attending training requested by the individual or family member/caregiver that relates to services described in the ISP;

10. Accompanying the individual to appointments or meetings; and

11. Assistance in the workplace with activities not already required or funded by another source (may include activities such as assistance with filing, retrieving work materials that are out of reach; providing travel assistance for an individual with a mobility impairment; helping an individual with organizational skills; reading handwritten mail to an individual with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment).

Criteria

In order to qualify for CD-PA services, the individual must demonstrates a need for assistance with activities of daily living, community access, medication, or other medical needs, or monitoring health status or physical condition. The individual must require some assistance with activities of daily living (ADLs) in order to obtain authorization for CD-PA services.

The case manager may request a change in the amount of authorized hours for CD Personal Assistance services on the ISP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

Other Criteria

Training is not an expected activity under CD-PA.

Medicaid reimbursement is only available for CD-PA services provided when the individual is present (with the exception of the assistant's attendance at training per the request of the individual or family member/caregiver) and a qualified assistant is providing the services. DMAS will reimburse the personal assistant only for services rendered to the individual.

DMAS will not reimburse the personal assistant for services rendered to or for the convenience of other members of the household (e.g., cleaning rooms used by all family members, cooking meals for the family, washing dishes, family laundering, etc.). DMAS also will not reimburse for the provision of unauthorized services.

Transportation

The personal assistant may transport the individual in the individual's primary vehicle or accompany the individual in order to implement the individual's ISP. The personal assistant may drive the individual only in the individual's primary vehicle, if all of the following criteria are met:

- The total time required by the personal assistant for the day, including the time required to drive the individual, does not exceed the individual's weekly authorized hours. If the total time required exceeds the daily hours, the additional time may be deducted from another day in that week as long as this does not jeopardize the individual's health and safety;
- The vehicle is registered in the Commonwealth of Virginia;
- The owner of the vehicle has current automotive insurance containing collision, comprehensive, and liability coverage with a minimum of 100-300-50. The insurance must insure the individual and cover the personal assistant as a driver of the vehicle;
- The personal assistant has a valid Virginia driver's license; and
- The performance of this service is necessary to implement the individual's ISP.

Service Units and Service Limitations

Personal assistants are paid an hourly rate. Personal assistants are paid by the Fiscal Agent on behalf of the individual once the timesheet is signed by the assistant and individual and forwarded to the fiscal agent. The timesheet is sent to the Fiscal Agent (with a copy kept for the CD Services Facilitator) by the individual or family member/caregiver biweekly.

Restrictions with Other Services

CD-PA services may not be authorized for an individual who receives MR Waiver Congregate Residential Support.

CD-PA services may not be provided during the same billable hours as MR Waiver Supported Employment or Day Support. Limited exceptions, in the case of Supported Employment, may be requested of DMHMRSAS for individuals who require assistance in the workplace (see number 11 in the "Activities," section above).

The amount of CD-PA services that can be authorized is determined by the individual's needs and required supports.

Work-related CD-PA services will only be available to individuals who also require Personal Assistance services to meet their ADLs. Workplace supports through the MR Waiver will not be provided if they are services provided by the Department of Rehabilitative Services under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act or Section 504 of the Rehabilitation Act. Work-related Personal Assistance services will not duplicate services provided under supported employment.

Provider Documentation Requirements

Documentation must clearly indicate the dates and times of CD-PA services delivery (i.e., timesheets).

RESPITE SERVICES (CONSUMER-DIRECTED)

Service Definition

Consumer-Directed Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These services are provided on a short-term basis because of the emergency absence or need for periodic or routine relief of the primary caregiver. They are provided in an individual's home, other community residence, and other community sites.

Activities

The allowable activities include, but are not limited to:

1. Assistance with personal care activities such as: bathing or showering, toileting, routine personal hygiene skills, dressing, transferring, etc.;

2. Assistance with monitoring health status and physical condition;

3. Assistance with self-medication and other medical needs;

4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);

5. Assistance with housekeeping activities, such as bed-making, dusting and vacuuming, laundry, grocery shopping, etc., when specified in the individual's ISP and essential to the individual's health and welfare;

6. Support to assure the safety of the individual;

7. Assistance with bowel/bladder programs, range of motion exercises, routine wound care which does not include sterile technique, and external catheter care (see the "Exhibits" section at the end of this chapter for more details.);

8. Attending training requested by the individual or family member/caregiver that relates to services described in the ISP;

9. Assistance or support, or both, needed by the individual to participate in social, recreational, or community activities; and

10. Accompanying the individual to appointments or meetings.

Criteria

When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) which are incidental to the services furnished, or which are essential to the health and welfare of the individual. CD-Respite services shall not include either practical or professional nursing services as defined in the Nurse Practice Act.

Training of the individual is not expected with CD-Respite services.

The case manager may request a change in the amount of authorized hours for CD-Respite services on the ISP at any time this is justified by individual need. (See "Authorization of MR Waiver Services" in this chapter for details.)

Reimbursement is available only for CD-Respite services provided when the individual is present (with the exception of the assistant's attendance at training per the request of the individual or family member/caregiver) and when a qualified provider is providing the services.

Transportation

The respite assistant may transport the individual in the individual's primary vehicle or accompany the individual in order to implement the individual's ISP. The respite assistant may drive the individual only in the individual's primary vehicle, if all of the following criteria are met:

- The total time required by the respite assistant for the day, including the time required to drive the individual, does not exceed the individual's authorized hours;

- The vehicle is registered in the Commonwealth of Virginia;

- The owner of the vehicle has current automotive insurance containing collision, comprehensive, and liability coverage with a minimum of 100-300-50. The insurance will insure the individual and cover the respite assistant as a driver of the vehicle;

- The respite assistant has a valid Virginia driver's license; and
- The performance of this services is necessary to implement the individual's ISP.

Service Units and Service Limitations

Respite assistants are paid an hourly rate. Respite assistants are paid by the Fiscal Agent on behalf of the individual, once the timesheet is signed by the assistant and individual and forwarded to the Fiscal Agent. The timesheet is sent to the Fiscal Agent (with a copy kept for the CD Services Facilitator) by the individual or family member/caregiver biweekly.

Restrictions

CD-Respite services may not be authorized for an individual who receives MR Waiver Congregate Residential Support, or to an individual living in a licensed Assisted Living Facility.

CD-Respite services are limited to 720 hours per individual per calendar year. Those who receive CD-Respite and Agency-Directed Respite services cannot receive more than 720 hours combined.

Provider Documentation Requirements

Documentation must clearly indicate the dates and times of CD Respite services delivery (i.e., timesheets).

ELIGIBILITY FOR MR WAIVER SERVICES

Diagnostic Eligibility

In order for an individual six years of age or older to meet diagnostic eligibility for MR Waiver services, the individual must have a psychological evaluation completed by a licensed professional that states a diagnosis of mental retardation and this evaluation must be maintained in the case management record. This psychological evaluation must reflect the individual's current level of functioning and meet the requirements for a diagnosis of mental retardation as defined by AAMR:

> "Substantially limited in present functioning that is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two

> or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work, manifested before age 18."

The psychological evaluation must address intellectual functioning, adaptive behavior, and age of onset.

In order for an individual under age six to meet diagnostic eligibility for MR Waiver services, the child must have a psychological or standardized developmental evaluation that states that the child has a diagnosis of mental retardation (as defined above) or is at developmental risk. Developmental risk is defined in the state regulations as:

> "The presence before, during, or after birth of conditions typically identified as related to the occurrence of a developmental disability and for which no specific developmental disability is identifiable through available diagnostic and evaluative criteria."

The psychological or developmental evaluation must be filed in the case management record and must reflect the child's current level of functioning.

Functional Eligibility

In order to meet functional eligibility for MR Waiver services, all individuals receiving MR Waiver services must meet the Intermediate Care Facility for the Mentally Retarded (ICF/MR) level of care. This is established by meeting the indicated dependency level in two or more of the categories on the Level of Functioning (LOF). Guidance for completing the LOF for children may be found in the "Developmental Milestones" chart (see the "Exhibits" section at the end of this chapter). The case management record must contain an LOF completed no more than six months prior to the start date of MR Waiver services, and completed at the annual renewal of services.

The case manager shall complete the assessment, determine whether the individual meets the ICF/MR criteria by completing the LOF, the developmental milestones document for children under 6 years of age, and develop the CSP with input from the individual, family members, service providers and any other individuals involved in the individual's maintenance in the community. Although the case manager has the responsibility of completing the LOF, this may be done in conjunction with family members and service providers. The LOF may not be completed in its entirety, by either the family of the individual or service providers.

Financial Eligibility

It is the responsibility of DSS to determine an individual's financial eligibility for Medicaid. Medicaid policies regarding the eligibility of individuals who receive Home and Community-Based Services allow a different method for determining income and resource eligibility. Some individuals not otherwise eligible for Medicaid may be eligible to receive MR Waiver services. Additionally, some of these individuals may also have a patient pay responsibility. For all individuals applying for MR Waiver Services, DSS must receive a Patient Information

form (see DMAS-122 in the "Exhibits" section at the end of this chapter) and a MR Waiver Level of Care Eligibility form (see DMH 885E 1161 in the "Exhibits" section at the end of this chapter) from the CSB/BHA case manager in order to make these determinations (see "Authorization of MR Waiver services" later in this chapter for case manager responsibilities). Eligibility requirements, patient pay determination and additional responsibilities are described in more detail later in this chapter.

SLOT ALLOCATION AND WAITING LIST CRITERIA

Waiting List

All CSBs/BHAs will be responsible for maintaining their own waiting list for the MR Waiver. The waiting list maintained by the CSB/BHA shall consist of three categories: urgent, non-urgent and the planning list. DMHMRSAS will maintain the Statewide Waiting List to include the CSBs' urgent and non-urgent lists. The urgent category criteria are outlined later in this section. The non-urgent category consists of those who meet the diagnostic and functional criteria for the waiver, including the need for services within 30 days, but who do not meet the urgent criteria. The planning list category consists of those who need services in the future. The MR Waiver is "needs based" with those in the urgent category being given priority. Only after all individuals in the State who meet the urgent criteria have been served can individuals in the non-urgent category be served.

The CSB/BHA must maintain documentation with the reasons the individual meets the urgent criteria. If a waiver slot becomes vacant or when a new waiver slot is allocated, the CSB/BHA is responsible for assigning the waiver slot to an individual from the urgent category. DMHMRSAS will confirm that the waiver slot is available to the CSB/BHA and that the individual has previously been included on the Statewide Urgent Need of Waiver Services Waiting List or newly meets the Urgent Need criteria. The CSB/BHA will determine, from among the individuals included in the urgent category, who should be served first, based on the needs of the individual at the time a waiver slot becomes available and not on any predetermined numerical or chronological order.

The urgency of need of individuals on the CSB's/BHA's waiting list is to be evaluated quarterly by the case manager, who will make additions and deletions to the urgent and non-urgent categories as needed and forward to DMHMRSAS any modifications to the Statewide Urgent Need of Waiver Services Waiting List. When the individual is first placed on the Waiting List or if an individual is moved from the urgent to non-urgent waiting list category, he or she is to be notified in writing by the case manager within 10 days and given appeal rights.

Urgent Criteria

The urgent category will be assigned when the individual is in need of services because he or she is determined to be at significant risk. Assignment to the urgent category may be requested by the individual, his or her legal guardian, or primary caregiver. The urgent category may be assigned only when the individual or legal guardian would accept the MR Waiver service if it were offered.

Satisfaction of one or more of the following criteria shall create a presumption that the individual is at significant risk and indicate that the individual should be placed on the Urgent Need of Waiver Services Waiting List:

1. Primary caregiver(s) is/are 55 years or older;

2. The individual is living with a primary caregiver who is providing the service voluntarily and without pay and the primary caregiver indicates that he or she can no longer care for the individual with mental retardation;

3. There is a clear risk of abuse, neglect, or exploitation;

4. The primary caregiver has a chronic or long term physical or psychiatric condition or conditions which significantly limit his or her ability to care for the individual with mental retardation;

5. The individual is aging out of a publicly funded residential placement or otherwise becoming homeless (exclusive of children who are graduating from high school); or

6. The individual with mental retardation lives with the primary caregiver and there is a risk to the health or safety of the individual, primary caregiver, or other individual living in the home due to either of the following conditions:

    a. The individual's behavior or behaviors present a risk to himself or others which cannot be effectively managed by the primary caregiver even with generic or specialized support arranged or provided by the CSB/BHA; or

    b. There are physical care needs (such as lifting or bathing) or medical needs that cannot be managed by the primary caregiver even with generic or specialized supports arranged or provided the CSB/BHA.

Slot Allocation

Enrolling new individuals into the MR Waiver occurs through the allocation of slots to the CSB/BHA. Additional waiver slots will only be available through the State budget process and after the Appropriation Act is signed. As waiver slots become available, they will be allocated to CSBs/BHAs based on the percentage of urgent cases when compared to the statewide total of urgent cases. CSBs/BHAs not having individuals who meet the urgent criteria will not be given a waiver slot allocation until all individuals in the State who meet the urgent criteria have been served.

CSBs/BHAs may not target a particular subcategory of applicants in the selection process when assigning waiver slots (for example, selection of adults over children, applicants with elderly caregivers only, or other criteria not directly related to the needs of the individual and family at the time the individual is enrolled). DMAS and DMHMRSAS will evaluate the distribution of services to all eligible populations. DMAS will review the documentation on

individuals who are included in the urgent category and those in the non-urgent category during utilization review visits.

DMHMRSAS will maintain a separate pool of waiver slots for individuals who are ready for discharge from state-operated facilities. The Office of Mental Retardation at DMHMRSAS will track waiver-eligible individuals discharged from state-operated facilities. If the individual is readmitted to a state-operated facility within 24 months of discharge, and the admission is a long-term admission, the waiver slot will revert to the statewide pool for state-operated discharges. If the discharged individual resides in the community for 24 consecutive months following discharge, the waiver slot will revert to the CSB/BHA providing case management services during the 24th month of community residence.

Slots can be adjusted among CSBs/BHAs when the following two situations occur:

- An individual who has been discharged from a state-operated facility is readmitted to a state-operated facility within 24 months of discharge; or

- Case management is transferred from one CSB/BHA to another CSB/BHA.

  If case management for an individual receiving waiver services is transferred from one CSB/BHA to another, the waiver slot for that individual will also be transferred to the new CSB/BHA. The transferring CSB/BHA will transfer case management responsibility within 90 days of residency in another service area unless one of the following conditions are met: (See the section later in this chapter entitled "Transferring Case Management Procedures" on transferring case management responsibility.)

  1. The family, guardian, or authorized representative has expressed a choice to continue case management services with the current CSB/BHA, and the current CSB/BHA is willing and able to provide case management and can demonstrate the capacity to handle emergency situations. However, if the CSB/BHA that serves the area in which the individual resides must provide MR emergency/crisis services (versus mandated Mental Health emergency/crisis services) outside of the MR Waiver at any time, case management and the waiver slot will be transferred within 30 days to the CSB/BHA in which the individual resides. In this instance, the current CSB/BHA will be deemed unable to provide case management services. This requirement is necessary to ensure the health and safety of the individual; or

  2. The placement in another CSB/BHA service area is temporary (90 days or less), i.e., another provider is developing a program to which the individual will return.

When an individual's case management services are transferred to another CSB/BHA, the waiver slot is transferred to that CSB/BHA and becomes part of its pool of available waiver slots.

APPLICATION FOR MR WAIVER SERVICES

The case manager's responsibilities are as follows:

1. Meets with the individual (and legal guardian, family members, and other interested persons, as applicable), within 30 calendar days of determining the individual meets functional criteria for the MR Waiver, and determines the individual's needs and supports necessary to provide appropriate services to the individual;

2. Obtains the individual's (or guardian's, if applicable) consent and signature(s) on the DMAS-20 "Consent to Exchange Information" in order to gather information from other sources and communicate to DMAS. For a sample, see the "Exhibits" section at the end of this chapter;

3. Confirms diagnostic and functional eligibility by obtaining or completing the following:

   - A psychological evaluation, or a standardized developmental evaluation for children under six years of age; and
   - An ICF/MR Level of Functioning Survey (LOF).

4. Informs the individual (guardian or family, as applicable) of the full array of MR services available for which he or she is eligible (including Consumer and Agency-Directed services) and documents the individual's choice of Waiver services or institutional care by signatures on the "Documentation of Recipient Choice between Institutional Care or Home and Community-Based Services" forms.

5. Determines if the individual meets the urgent criteria.

6. Informs the individual (guardian or family as applicable) of non-MR Waiver services for which he or she is eligible.

7. If the individual selects MR Waiver, submits required documentation to the Office of Mental Retardation, DMHMRSAS for enrollment or placement on the Statewide Waiting List.

8. If the individual selects ICF/MR placement, assists the individual with this option. If the individual chooses ICF/MR placement and is placed on a waiting list, he or she may be placed on either the MR Waiver Statewide Urgent or Nonurgent Waiting List at the same time.

PLACEMENT ON THE STATEWIDE WAITING LIST

If diagnostic and functional eligibility are met and the applicant selects MR Waiver, but the CSB/BHA does not have a waiver slot available for the individual, the following documentation is required by DMHMRSAS for placement on either the MR Waiver Statewide Urgent or Nonurgent Waiting List:

1. The completed MR Waiver Enrollment Request, indicating Urgent or Non-Urgent Needs Status; and

2. The signed Recipient Choice form.

DMHMRSAS will notify the appropriate CSB/BHA that the individual has been added to the Statewide Urgent Needs List or the Non-Urgent Needs List. DMHMRSAS will maintain the documentation that the individual has been added to a statewide waiting list for a period of five years. The case manager must notify the individual in writing that he or she has been placed on the Statewide Urgent Needs Waiting List, or the Non-Urgent Needs List, and of his or her appeal rights (see the "Recipient's Right to Appeal" section of this chapter for details) within 10 days of receiving this information from DMHMRSAS.

ENROLLMENT INTO THE MR WAIVER

If diagnostic and functional eligibility are met, the applicant elects to receive MR Waiver services and the CSB/BHA has a waiver slot available for the individual, the following documentation is required by DMHMRSAS for enrollment (unless previously submitted for placement on the Waiting List and if the information remains current):

1. The completed MR Waiver Enrollment Request,

2. The completed LOF, completed no earlier than 6 months prior to enrollment, and

3. The signed "Documentation of Recipient Choice Between Institutional Care or Home and Community-Based Services" form.

DMHMRSAS will notify the CSB/BHA that the individual has been enrolled as requested or that additional information is needed. Once enrollment is complete, DMHMRSAS will forward the approved Enrollment Request and the MR Waiver Level of Care Eligibility Form (see the "Exhibits" section at the end of this chapter) to the case manager, who continues with the service authorization process as described on the following pages.

AUTHORIZATION OF MR WAIVER SERVICES

Once DMHMRSAS has verified that the CSB/BHA has an available waiver slot to be used by a designated individual, the individual or case manager shall contact service providers so that the individual may receive services within 60 days. If services are not initiated by any service provider within 60 days, the case manager must submit information to DMHMRSAS and copy the individual or individual's family demonstrating why more time is needed to initiate services. Requests for extensions may be submitted to DMHMRSAS and copied to the individual or individual's family in 30-day extension periods by using the "Request to Retain

Slot for Individual Not Currently Receiving MR Waiver Services" form (See DMH 885E in the "Exhibits" section). DMHMRSAS has the authority to approve, suspend, or deny the request to retain the waiver slot.

Final recommendation for authorization of MR Waiver services is the responsibility of DMHMRSAS, upon recommendation from the Case Management provider and review of the documentation materials. DMAS has the final authority on all approvals. Following receipt of written notification from DMHMRSAS that the individual will be enrolled in the MR Waiver, the case manager completes the following actions:

1. Completes the information on the MR Waiver Level of Care Eligibility Form (DMH 885E 1164), along with the DMAS 122 (see the "Case Management Provider's Responsibility for the Patient Information Form" section later in this chapter and the "Exhibits" section for copies of these forms) and forwards them to DSS for MR Waiver financial eligibility determination and patient pay responsibilities.

2. Obtains a medical examination that is completed no more than one year prior to the start date of Waiver services and ensures the case management file contains a copy of this document.

3. Determines that the psychological evaluation or standardized developmental evaluation for those under six years of age reflects the individual's current status and ensures the case management file contains a copy of this document.

4. Ensures that the DMHMRSAS-approved functional assessment instrument, is completed no more than one (1) year prior to the start date of services, and that the LOF is completed no more than six (6) months prior to the start date of services.

5. Updates any evaluative or assessment documents, as necessary, to comply with timeline requirements.

6. Assists the individual in developing personal goals and desired outcomes of services.

7. Obtains input from the individual, family, or guardian, and other interested parties.

8. Completes the Social Assessment (described earlier in Chapter IV) no more than one (1) year prior to the start of services, and reviews with the applicant (and family or guardian, if applicable), all the assessments and information gathered, including, but not limited to, the LOF, psychological evaluation, DMHMRSAS approved functional assessment, and medical examination.

9. Re-evaluates and agrees upon the needed services for providing appropriate services to the individual.

10. Identifies and shares with the applicant and family or guardian, if applicable, all available service providers. It is suggested that the Statewide MR Waiver provider list be shared with the individual (and family or guardian).

11. Arranges for visits or interviews with the providers as desired by the individual or family/caregiver.

12. Confirms that any interested provider, including the CSB/BHA, has been enrolled with DMAS as a MR Waiver provider of the specific service under consideration. A provider must have a current DMAS Participation Agreement that lists all services for which the provider is eligible to provide and bill (see Chapter II for details).

13. Documents in writing and maintains in the case management file the individual's choice of MR Waiver providers. This documentation must indicate the specific choice(s) made by the individual.

14. Coordinates a meeting with the individual, service providers, and significant others to complete the CSP, which includes the Social Assessment, primary goals or desired outcomes, documentation of agreement, ISPs, and start dates of services (see additional details in "Case Management Services" earlier in this chapter).

15. Reviews the ISPs submitted by the providers to confirm that they:

    - Designate supports based upon input from the individual and as noted in the assessment information and agreed to by the team;
    - Are specific and measurable;
    - Include a schedule of when the provider will offer these supports and services;
    - Include activities that are allowable for Medicaid (service providers must maintain responsibility for assuring all services meet Medicaid requirements);
    - Indicate the total weekly hours or units;
    - Indicate the correct start date;
    - Indicate the quarterly review due dates, which correspond to the Case Management review dates (CSP dates); and
    - Include an ISAR consistent with the information on the ISP.

    For any MR Waiver service provider to begin services, to modify the amount or type of services, or to end services, an ISAR must be reviewed and approved by the case manager and submitted to DMHMRSAS for final authorization. It is the responsibility of the case manager to assure that ISARs are submitted to

DMHMRSAS as needed. An ISAR may be submitted at any time during the year, but the information on the ISAR must clearly describe the reason for the action and include the signature of the case manager; and

16. Submits to DMHMRSAS the following documents (see the "Exhibits" section at the end of this chapter):

    - The Plan of Care Summary Form;
    - ISARs that have been signed by the case manager, and for which start dates have been determined. Additional ISARs for eligible individuals may be submitted at later dates as needed and described in the following sections; and
    - An up-to-date Social Assessment.

    NOTE: Initiation of MR Waiver services prior to appropriate authorization may not be reimbursed by DMAS.

Individual Service Authorization

Authorization of services cannot take place prior to the date of receipt by DMHMRSAS of a correct, complete ISAR. While a requested start date up to the date of receipt of correct, complete ISARs for eligible individuals shall be honored, to assure the provider that the individual is eligible and that services are authorized as requested, it is recommended that the required documents be submitted at least 10 to 30 working days prior to the requested start of services. All authorization requests will be acted upon within 10 working days following receipt by DMHMRSAS. DMHMRSAS will review the documentation to determine MR Waiver eligibility and appropriateness of services, and approve, deny, or pend approval until receipt of additional information.

When Waiver services are approved by DMHMRSAS, the case manager will be notified via an ISAR, and for all services (excluding CD Services, Agency-Directed Companion Services, PERS and Prevocational Services), a Notice of Approval of Pre-Authorized Services (see the "Exhibits" section at the end of this chapter) will be sent to the individual and the specified service provider notifying them of the action taken by DMHMRSAS and the authorized start date of services. For the services noted above, for which a Notice of Approval is not generated, the case manager is responsible for forwarding a copy of the ISAR to the service provider.

If the requested services are denied, the case manager will be notified and a DMAS notification letter will be sent (excluding those services noted above) to the individual and specified service provider notifying them of the action taken by DMHMRSAS and the reason for the denial. The notification letter to the individual will explain the individual's appeal rights and procedures. Any requests for services that are denied may be resubmitted at a later date, if additional justification is obtained.

If DMHMRSAS pends approval of services, notification will be sent to the Case Management provider, explaining the reason for this action and any additional information or action that is required of the provider or case manager. If the requested information is submitted (within 30 calendar days and confirming eligibility or justifying the appropriateness of services), services may be approved as of the requested start date on the ISAR. If the requested information is not received within 30 days, the request will be rejected and the provider, via the case manager, will have to resubmit the request. Whenever services are denied or rejected, a new ISAR must be submitted with a new start date and the required justification for reconsideration by DMHMRSAS. Case managers are encouraged to use the comment sections on the required forms or attach additional pages to explain unusual circumstances.

MR Waiver services commencing before the start date on the DMAS-generated pre-authorization notification letter will not be reimbursed by DMAS.

Case Management Provider's Responsibility for the Patient Information Form (DMAS-122)

The Patient Information form (DMAS-122) is used by the case management provider and the local DSS to exchange information regarding the individual's financial eligibility for long-term care and waiver services, the responsibility of a Medicaid eligible individual to make payment toward the cost of services, and other information that may affect the eligibility status of an individual. The provider is responsible for ensuring that a current, completed DMAS-122 is in the individual's record. The local DSS generates a new DMAS-122 at least annually. If a DMAS-122 is not generated by the local DSS annually and repeated documented attempts to obtain the form are unsuccessful, the case manager should report this information to the regional DMHMRSAS Community Resource Consultant.

For any individual enrolled in the MR Waiver, the case manager must forward the DMAS-122 with the top portion completed, along with a copy of the MR Waiver Level of Care Eligibility Form (see the "Exhibits" section at the end of this chapter for the DMH 855E 1164) to the local DSS indicating the individual has met the level of care requirements. Following verification that the individual has been screened and approved to receive MR Waiver services, the eligibility worker will determine the individual's Medicaid eligibility, complete the DSS portion of the DMAS-122 and return it to the case manager noting any patient-pay obligation of the individual.

The completed DMAS-122 form in conjunction with the preauthorization notification serves as the provider's authorization to bill for waiver services, as well as to identify the individual's financial responsibility toward the cost of services. Services rendered prior to the receipt of the completed DMAS-122 from DSS are at risk of non-payment or overpayment for either of the following reasons: the individual is found to be financially ineligible for Medicaid or the provider bills DMAS for services that are the financial responsibility of the individual as indicated in the patient pay amount. The eligibility worker will return the same DMAS-122 to the case manager with the bottom section completed, showing confirmation of the individual's Medicaid identification number, the individual's income, any patient pay obligation and the date on which the individual's Medicaid eligibility was effective. A copy of the completed DMAS-122 must be maintained in the individual's case management file.

Patient Pay

Each individual receiving Medicaid Home and Community-Based Care MR Waiver services is allowed to keep a portion of his or her income to meet his or her own maintenance needs. This maintenance allowance is higher for the individual staying at home in community-based services than for the individual living in an ICF/MR. The maintenance allowance for individuals participating in waiver services is equal to 100% of the current Supplemental Security Income (SSI) individual payment standard.

Virginia reduces its payment for MR Waiver services by the amount of the individual's total income that remains after allowable deductions for "personal maintenance needs," and earnings from employment. The maintenance allowance and any other allowable deduction (e.g., medical insurance payments) are deducted from the individual's income to arrive at that individual's patient pay amount. The patient pay will be figured into the amount owed to the provider, and the individual will be responsible for giving the provider the patient pay as payment for services. Should the patient pay equal or exceed the cost of waiver services, the individual will pay the provider the full amount due for waiver services. DMAS will reimburse the providers only for services that are not covered by the patient pay.

It is the responsibility of the case manager to carefully review the DSS-completed DMAS-122 for financial eligibility and patient pay obligations. The provider with the greatest number of hours or units (dollar amount) of MR Waiver services will be designated as the collector of the patient pay amount. The case manager must identify on the DMAS-122 the provider with the greatest number of hours and inform them that they must collect the patient pay amount. The case manager must 1) distribute a copy of the DMAS-122 completed by the DSS eligibility worker to each provider (regardless of any patient pay responsibility), and 2) maintain a copy in the individual's case management file. It is the responsibility of the case management provider to assure that a DMAS-122 for the current year is in the individual's record.

Additional Uses of the DMAS-122

Following the initial DMAS-122, the case manager must complete an updated DMAS-122 and forward it to the local DSS eligibility worker whenever an individual experiences any of the following changes:

- A new address;
- A different provider providing case management services;
- An increase or decrease in monthly income;
- Discharge from all MR Waiver services (see the "Discharging an Individual from All MR Waiver Services" section later in this chapter);
- An interruption in all MR Waiver services for more than 30 days; or
- Death.

The exact change in circumstances and reason for the change must be clearly noted on the DMAS-122. The case manager should then distribute the DMAS-122 received back from DSS to all MR Waiver providers. DSS is responsible for notifying the case manager if the individual no longer meets eligibility requirements.

Increases in hours or units or the addition or deletion of a Waiver service or a provider do not require a new DMAS-122 form (See the "Discharging an Individual from All Waiver Services" and "Interruption of Services" sections later in this chapter for additional information specific to these situations.)

Pending Medicaid Eligibility

If services are approved, but the ISAR cannot be processed upon receipt by DMHMRSAS due to a pending Medicaid number, DMHMRSAS will notify the case manager that entry into the MMIS is pending Medicaid eligibility. Once the Medicaid number has been issued by DSS, the case manager must notify DMHMRSAS by phone or fax, in order to complete the authorization process.

Modifications to Services During the CSP Year

To change the amount or type of service previously authorized, a new ISAR must be reviewed and approved by the case manager and submitted to DMHMRSAS for final authorization.

All requests for new services or increases in existing hours or units will be reviewed under the health and safety standard. This standard assures that an individual's right to receive a service is dependent on a finding that the individual needs the service, based on appropriate assessment criteria. A narrative describing the individual's assessed need for the service must be submitted along with the ISAR.

Multiple Providers

If the individual will be receiving the same service from more than one provider, the case manager should clearly describe the circumstances to DMHMRSAS on the Plan of Care Summary during pre-authorization. If changes occur during the CSP year when submission of the Plan of Care Summary is not required by DMHMRSAS, the circumstances should be clearly described on the ISARs.

Changing Providers

To change a provider for an approved service, the case manager must submit to DMHMRSAS an ISAR to terminate the services of the existing provider and an ISAR to begin services with the new provider.

Ending Individual Services

When services from a MR Waiver provider terminate, an ISAR terminating services must be submitted to DMHMRSAS. DMHMRSAS will determine whether any billing has occurred beyond the requested termination date. If such billing has occurred, the provider will be contacted by DMHMRSAS to make the correction.
All termination ISARs must include the detailed reason for the termination in the comments section.

60-Day Assessments

60-Day Assessment ISARs, if appropriate, are authorized for the CSP year. A new ISAR is not required by DMHMRSAS to continue the service after the 60-day period, but an annual plan, developed with the involvement of the individual, must be forwarded to the case manager for review approval prior to the end of the 60 days.

Discharging an Individual from All MR Waiver Services

Reasons to discharge an individual from the MR Waiver are:

- Death;
- Individual moves to another state;
- Individual declines MR Waiver services;
- Individual no longer meets diagnostic or functional eligibility;
- Individual enters an ICF/MR, nursing facility or rehabiliation hospital;
- DSS determines that the individual is no longer financially eligible;
- Home and Community Based Care Services are not the critical alternative to prevent or delay ICF/MR placement;
- The individual's environment does not provide for his/her health, safety and welfare; or
- An appropriate and cost effective CSP cannot be developed.

In the event one of the above situations occurs, the case manager must complete the DMAS-122 to discharge the individual from the MR Waiver, terminate all MR Waiver services and forward the DMAS-122 to DMAS, DSS and DMHMRSAS, clearly noting the date of discharge and the exact reason for the discharge (e.g., discharged to a nursing facility, placement in an ICF/MR, deceased, moved to another state). ISARs terminating individual services are not needed when the individual will no longer receive any MR Waiver service.

Once an individual is discharged from the MR Waiver the individual must reapply with the CSB/BHA in order to receive MR Waiver services again.

Suspension of Waiver Services

In the event that Waiver Day Support, Prevocational or Supported Employment services are suspended according to the guidelines set forth herein, the provider should immediately notify the case manager so that the case manager may notify the individual of his/her right to appeal the action in one of the following ways:

1. Send a completed copy of the notification/right to appeal letter with the individual as he/she is leaving the program.. The provider would maintain blank copies of the letter and would complete the information via phone with the CM, obtaining a "verbal signature" for the letter from the CM;

2. Hand deliver a copy of the notification/right to appeal letter to the individual's place of residence by close of business day on the day of suspension;

3. Fax the notification/right to appeal letter to the individual's place of residence by close of business on the day of the suspension.

Interruption of Services

Holding Waiver Slots

Whenever services are interrupted or the individual must be discharged from MR Waiver (as outlined above), but on a temporary basis only (e.g., temporary loss of financial eligibility, health and safety at risk in current situation, discharged to a rehabilitation hospital or ICF/MR), the waiver slot must be held for at least 60 days to allow that individual to return to services. If services are not re-initiated within 60 days, the case manager must submit information to DMHMRSAS and copy the individual or individual's family demonstrating why more time is needed to re-initiate services, by using the "Request to Retain Slot for Individual Not Currently Receiving MR Waiver Services" form (See "DMH 885E" in the "Exhibits" section at the end of this chapter). DMHMRSAS has the authority to approve or suspend the request in 30-day extensions or to deny the request to retain the waiver slot.

No MR Waiver Services for More than 30 Days

If an individual does not receive MR Waiver services for more than 30 days, the case manager must notify DSS via a DMAS-122 form. DSS will determine if the individual continues to meet financial eligibility requirements for Medicaid and return the completed DMAS-122 to the case manager.

If DSS informs the case manager via the DMAS-122 that the individual's financial eligibility for Medicaid is unaffected and the person is expected to return to Waiver services, no further authorization steps are needed at this point. Services will remain authorized.

Once DSS returns the completed DMAS-122 to the case manager, the case manager must then forward the DMAS-122 to DMAS and DMHMRSAS. DMHMRSAS will discharge the individual from the MR Waiver if DSS determined he or she is no longer financially eligible for Medicaid. If it is expected that this is a temporary discharge (no more than 60 days), the case manager must indicate that on the DMAS-122. DMHMRSAS will monitor the interruption of services and the retention of the waiver slot. When financial eligibility for Medicaid is terminated, the individual will no longer be eligible for Medicaid Targeted Case Management.

If DSS determined that the individual's financial eligibility for Medicaid is unaffected and the person is expected to return to Waiver services, services will remain authorized, but DMHMRSAS will monitor the interruption of services and the retention of the slot.

Individual Enters an ICF/MR or Rehabilitation Hospital

When services are interrupted due to the individual's entering an ICF/MR, nursing facility or rehabilitation hospital for temporary services, he or she must be discharged from the MR

Waiver with a DMAS-122 during this stay in order for that facility to be able to bill for services. The case manager must immediately notify the local DSS eligibility worker by phone and forward a DMAS-122 to DSS and at the same time to DMHMRSAS. The DMAS-122 must provide an explanation of the reason for the discharge and clearly indicate that this is a temporary interruption.

Resuming Services from ICF/MR or Rehabilitation Hospital Stay

Once the individual is ready to return to MR Waiver services, the case manager forwards a copy of the revised DMAS-122 to DMAS, DSS and DMHMRSAS, clearly explaining the return to services. New ISARs must be submitted to DMHMRSAS to resume services, and billing by service providers must reflect the new start dates. It is the responsibility of the case manager to review the DMAS-122 returned from DSS to assure continued financial eligibility and forward a copy to all providers.

Transferring Case Management

When an individual receiving MR Waiver services requests to move from one case management (CM) provider to another, the "referring" CM provider should notify the "receiving" CM provider, via a phone call, when it is known that the individual will be transferring. This contact should be followed by a letter that will formally inform the "receiving" CM provider of the planned move. The letter should contain:

- The individual's name,
- Medicaid number,
- Date of transfer,
- A listing of current services, providers, and approved funding for services, amd
- Any changes in providers or service levels that will occur with the move.

The "receiving" CM provider should submit to DMHMRSAS, as soon as possible:

- A copy of the referring CM provider's letter
- A new Plan of Care Summary form, and
- ISARs (if there are service level/provider changes).

Both CSBs/BHAs are responsible for completing the DMAS-122 and forwarding to their local DSS to explain the transfer.

MONITORING AND RE-EVALUATION OF THE SERVICE NEED

The case manager must continuously monitor the appropriateness of the individual's CSP and make revisions in the CSP as indicated. At a minimum, the case manager shall review the CSP every three months to determine if service goals and objectives are being met, assess the individual's satisfaction with the services, confirm the status of the individual's health and welfare, and determine if any modifications are needed to the CSP.

The Case Management review process is as follows:

1. Case Management quarterly reviews must be written and should include a review of ALL MR Waiver Services included in the CSP, in addition to Case Management services. Quarterly reviews from the waiver service providers are filed in the case management record. The quarterly review schedule for individual providers is based upon the start date of the CSP;

2. Excluding Respite services (agency or consumer-directed), Assistive Technology, Environmental Modification, and Crisis Stabilization (which are considered sporadic and temporary services), all service providers must complete a written quarterly review and forward it to the case manager within the agreed upon time frame. If any of these sporadic and temporary services were provided during a quarter, the case manager would be required to obtain details of the services from the provider and include this information in the Case Management quarterly report;

3. Prior to the end of the CSP year, the case manager meets with the individual or legal guardian, or both, and service providers to reassess service needs and develop a new CSP, if services are to continue;

4. This new annual CSP must be completed prior to service delivery. However, the effective date of the new CSP would not need to begin until the previous one expires;

5. If the individual's needs change or there is a request for changes in services, providers can make revisions to the goals, objectives, or strategies of the ISP at any time during the CSP year.

    a. If the individual agrees to the changes, in collaboration with the case manager, the ISP is revised and an effective date for the change is stated on the ISP. Details of the revision would be documented and discussed at the quarterly review;

    b. If the total hours or units change at any time during the CSP year (additional services or ongoing increases or decreases in services), authorization is required. The case manager must have a revised ISP and ISAR form from the provider and forward the ISAR to DMHMRSAS for authorization within the required time frame;

    c. A new “Documentation of Recipient Choice Between Institutional Care or Home and Community-Based Services” form may be needed, along with an updated social assessment and an updated signature page, confirming the individual’s or guardian's agreement to the changes;

    d. A case manager can add a new service (ISP) to an existing CSP at any time during the CSP year with DMHMRSAS authorization; however, the

end date and quarterly review dates would coincide with the CSP year; and

e. The individual will be notified via DMAS notification letter of changes resulting in decreases or terminations in services. Individuals will be given the right to appeal at this time.

6. Every 365 days, a new CSP is required.

ANNUAL REASSESSMENTS

The Virginia Administrative Code (12 VAC 30-120-250) requires that the case manager complete a comprehensive reassessment (i.e., gather relevant social, psychological, medical and level of care information) in order to coordinate a new Consumer Service Plan (CSP) for each individual receiving MR Waiver services every year. The coordination of a CSP must include all the current MR Waiver ISPs and information on the non-waiver services to be maintained in the case management record. While the case manager must still complete an annual reassessment and facilitate the revised CSP, no annual renewals are to be sent to DMHMRSAS for plans that continue the same services and service units as in the previous year. The exceptions to automatic annual reauthorization are Assistive Technology, Environmental Modifications, Crisis Stabilization, and Crisis Supervision. These services are short-term services and require new ISARs. ISPs from the service providers are still required to be completed and submitted to the case manager prior to the end of the CSP year. Failure to do so could jeopardize the provider's ability to bill for services or the provider's DMAS participation agreement.

RECIPIENT'S RIGHT TO APPEAL AND FAIR HEARING

State (12 VAC 30-110-70 through 90) and Federal regulations (42 CFR § 431 et seq.) requires a notice of appeal rights to individuals who have had a Medicaid-covered service denied, suspended, reduced, or terminated.

The individual must be notified in writing of the right to a hearing and the procedure for requesting a hearing at the time of the application and at the time of any adverse action by DMAS, DMHMRSAS, the CSB/BHA, or DSS. For applicants and individuals not familiar with English, a translation of the appeal rights understood by the applicant or individual must be included. Appeal rights at the time of any adverse action by DMAS, DMHMRSAS, the CSB/BHA, or DSS must be issued in writing at least ten (10) days prior to the date of action, except for specified exceptions. The individual then has (30) days from the date of denial to request an appeal.

When initial MR Waiver services are authorized or whenever services for an individual already receiving MR Waiver services are increased, decreased, denied or terminated via an ISAR, a notification letter will automatically be generated through the DMAS MMIS and sent to the provider and individual. The individual's letter indicates the approved, decreased, terminated or denied services and limits and includes the right to appeal notification if services have been terminated, suspended, reduced, or denied. This notification letter is not generated for CD

Services, Agency-Directed Companion Services, PERS and Prevocational Services; therefore, the case manager is responsible for notifying the individual of the action and appeal rights with respect to these services.

In addition, in the cases below, because a notification letter is not generated by the DMAS MMIS, the case manager is responsible for notifying the individual in writing of the following actions and the right to appeal these actions:

1. An individual's request for a Medicaid-covered service (such as MR Waiver, ICF/MR, or SPO case management) is denied or offered at a decreased level. This does not mean that a particular provider cannot provide the service, it means that a particular service is determined to not be needed for a particular individual;

2. A request for an increase in hours or units or a request for additional services is denied by the CSB/BHA;

3. When the CSB/BHA is decreasing or terminating services and 10-days advance notice is required (as described below);

4. SPO Case Management services are terminated;

5. Individual meets MR Waiver criteria, is not enrolled in MR Waiver, but his or her name is placed on the urgent or non-urgent waiting list;

6. Individual is suspended from any service; and

7. Individual's name is moved from the urgent waiting list to the non-urgent list.

The contents of the notification letter must include: (See the "Exhibits" section at the end of this chapter for sample letters.)

1. What action the case manager or provider intends to take;

2. The reason(s) for the intended action;

3. The specific regulations that support, or the change in federal or state law that requires the action (12 VAC § 30 -110-70 through 90);

4. An explanation of the individual's right to request a hearing;

5. An explanation of the circumstances under which Medicaid is continued if a hearing is requested;

6. An explanation of the individual's requirement to reimburse DMAS if the appeal is unsuccessful, if the individual continues to receive a Medicaid covered service; and

7. The effective date of the action.

Advance Notification

Unless otherwise specified, written notification must be mailed by the case manager to the individual or legal guardian at least ten (10) days prior to the date of action when a provider reduces or terminates one or all Medicaid-covered service(s).

Exceptions to the 10-Day Advance Notice Requirement

The 10-day advance written notice is required to be sent to the individual or legal guardian from the case manager, except for the following reasons: (Note that the written notice is required, even though advance notice is not.)

1. When the case manager has factual information confirming the death of an individual;

2. When an individual or guardian provides a written request indicating that:

   a. He or she no longer wishes services; OR

   b. He or she gives information that requires termination or reduction and indicates an understanding of the action required by supplying this information;

3. The individual has been admitted to an institution and is ineligible for further services, including a regular admission to an ICF/MR, nursing home or rehabilitation hospital, or has been incarcerated;

4. The individual's whereabouts are unknown, as evidenced by returned mail;

5. The CSB/BHA establishes the fact that the individual has been accepted for Medicaid services by another state, Territory, or Commonwealth;

6. The individual's physician prescribes a change in the level of care;

7. The health and safety of the individual or others are endangered (if appropriate, the case manager must immediately notify the local DSS Adult Protective Services or Child Protective Services, as well as DMHMRSAS Offices of Human Rights and Licensing, as required); or

8. When the individual's request for admission into a Medicaid-covered service or when the individual's request for an increase in a Medicaid covered service is denied or not acted upon promptly for any reason.

All notification letters generated by the CSB/BHA must be filed in the case management record.

Appeals may be requested in writing to DMAS within 30 days of the notification of action. If the individual is currently receiving the services and requests a DMAS appeal hearing, the MR Waiver provider may not terminate or reduce services until a decision is rendered by the

hearing officer. After receiving confirmation from the DMAS Appeals Division that an appeal has been filed and prior to the date for the proposed change, the case manager must notify (verbally or in writing) the provider that an appeal is in process to enable the provider to continue services at the same level if the individual chooses. Similarly, the slot of an individual who has been terminated from the MR Waiver may not be allocated to another individual until the 60th day following notification of action. Should the individual file an appeal during that time frame, DMHMRSAS must be notified and the waiver slot must remain assigned to its current recipient until that individual's appeal rights have been exhausted.

Money paid for services provided to the individual as a result of the required continuation of services during the appeal process, may be recovered by DMAS if the decision is not in the individual's favor.

Provider Discontinues Services

In non-emergency situations in which a participating provider intends to discontinue services to an individual, the provider shall give the individual or family/caregiver and case manager 10 days advance written notification. The letter shall provide the reasons the provider is discontinuing services and the effective date. The effective date shall be at least 10 days from the date of the notification letter. The individual is not eligible for appeal rights in this situation and may pursue obtaining services from another provider.

In an emergency situation in which the health and safety of the individual or provider personnel is endangered, the 10-day advance written notification period shall not be required, however, the case manager must be notified prior to discontinuing services.

MAINTAINING RECORDS

Business and Professional Records

Providers must maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the business. An example of documents in this area is human resources documentation. These policies apply even if the provider discontinues operation. DMAS shall be notified in writing of the storage location and procedures for obtaining records for review should the need arise. The location, agent, or trustee shall be within the Commonwealth of Virginia; and

1. Such records must be retained for at least five years from the last date of service or as provided by applicable State laws, whichever period is longer. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every exception is resolved; and

2. Records of minors shall be kept for at least five years after such minor has reached the age of 18 years.

Individual Records

1. The CSB/BHA must maintain for each MR Waiver individual, the following documentation for review by DHMHRSAS and DMAS staff for a period not less than five years from the individual's last date of service or as provided by applicable State laws, whichever period is longer:

   a. The comprehensive assessment and CSPs;

   b. All ISPs from every provider;

   c. All supporting documentation related to any change in the CSP; and

   d. All related communication with the providers, individual, consultants, DMHMRSAS, DMAS, DSS, DRS or other related parties.

2. The service providers must maintain the following documentation for review by DMHMRSAS and DMAS staff for a period not less than five years from the individual's last date of service or as provided by applicable State laws, whichever period is longer:

   a. All assessment, reassessments, and ISPs;

   b. All attendance log documenting the date services were rendered and the amount and type of services;

   c. Appropriate data or progress notes reflecting the individual's status and, as appropriate, progress or lack of progress toward the goals on the ISP; and

   d. Any documentation to support that services provided are appropriate and necessary to maintain the individual in the home and in the community.